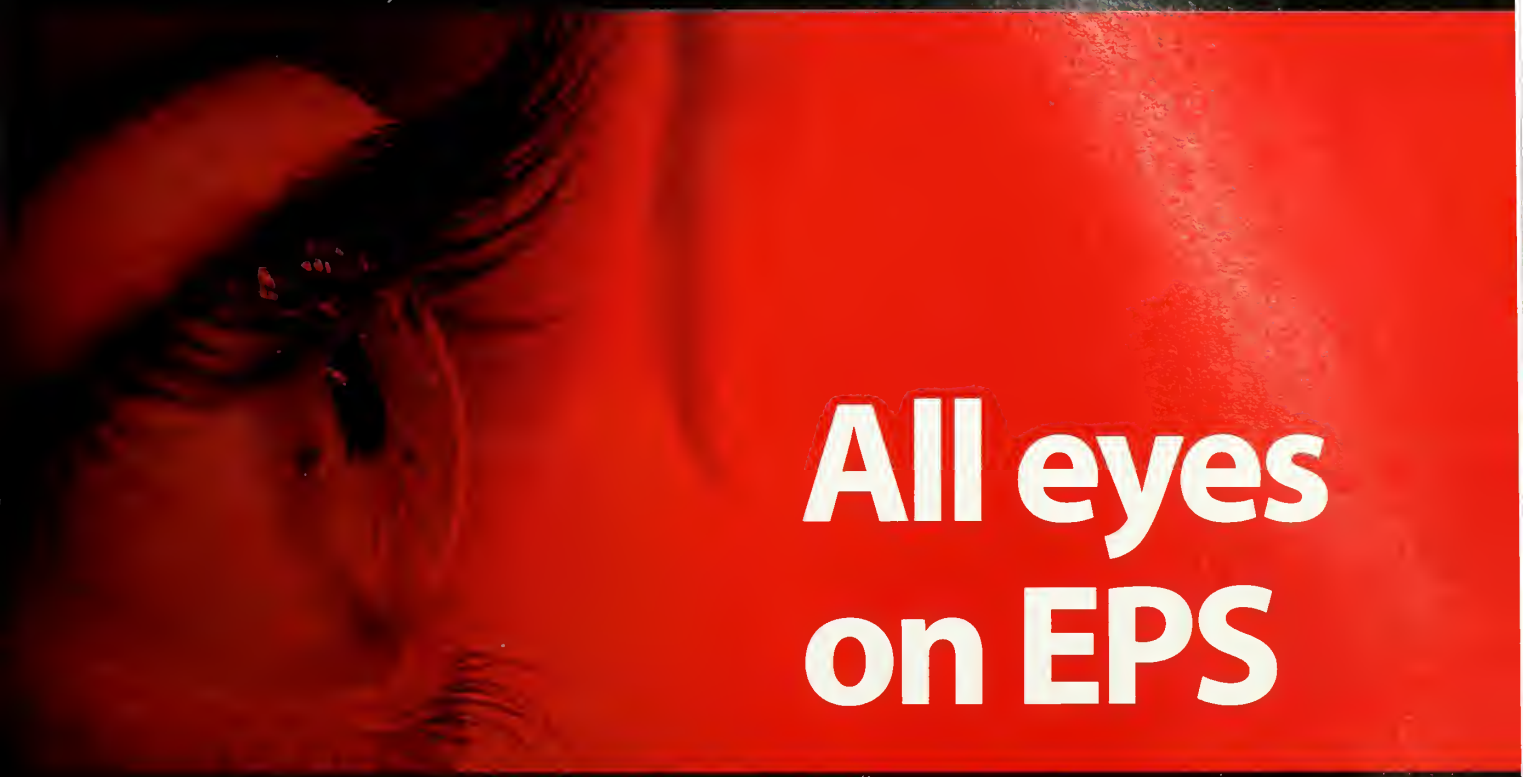
C+D

1859-2009

Celebrating 150 years in pharmacy

www.chemistanddruggist.co.uk

28 March 2009



All eyes on EPS

The meeting they tried to hide

See page 4

New

Avamys®▼

fluticasone furoate

Nasal and **ocular** symptom relief

Welcome to a world of **allergic rhinitis relief...**

Avamys is a new intranasal steroid providing relief from both nasal and ocular seasonal allergic rhinitis symptoms.

It's a once daily therapy available in an award winning device.

Not actual size

Prescribing Information
(Please refer to the full Summary of Product Characteristics before prescribing)
Avamys® ▼ Nasal Spray Suspension (fluticasone furoate 27.5 micrograms /metered spray) **Uses:** Treatment of symptoms of allergic rhinitis in adults and children aged 6 years and over. **Dosage and Administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily (total daily dose, 110 micrograms). Once symptoms controlled, use maintenance dose of one spray per nostril once daily (total daily dose, 55 micrograms). *Children aged 6 to 11 years:* One spray per nostril once daily (total daily dose, 55 micrograms). If patient is not adequately responding, increase daily dose to 110 micrograms (two sprays per nostril, once daily) and reduce back down to 55 microgram daily dose once control is achieved. **Contraindication:** Hypersensitivity to active ingredients or excipients. **Side Effects:** *Common:* nasal ulceration. *Very common:* epistaxis. Epistaxis was generally mild to moderate, with incidences in adults and adolescents higher in longer-term use (more than 6 weeks). **Precautions:** Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. Treatment with higher than recommended doses may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Caution when prescribing concurrently with other corticosteroids. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. Reduce to lowest dose at which effective control of symptoms is maintained or refer to paediatric specialist. May cause irritation of the nasal mucosa. Caution when treating patients with severe liver disease, systemic exposure likely to be increased. **Pregnancy and Lactation:** No adequate data available. Recommended nasal doses result in minimal systemic exposure. It is unknown if fluticasone furoate nasal spray is excreted in breast milk. Only use if the expected benefits to the mother outweigh the possible risks to the child. **Drug interactions:** Caution is recommended when co-administering with inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and ritonavir. **Presentation and Basic NHS cost:** Avamys Nasal Spray Suspension: 120 sprays: £6.44 **Market Authorisation number:** EU/1/07/434/003 **Legal category:** POM. **PL holder:** Glaxo Group Ltd, Greenford, Middlesex, UB6 0NN, United Kingdom. **Last date of revision:** December 2008

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to GlaxoSmithKline on 0800 221 441.

References:
1. Fokkens WJ, Jogi R, Reinartz S *et al.* Once daily fluticasone furoate nasal spray is effective in seasonal allergic rhinitis caused by grass pollen. *Allergy* 2007; **62**: 1078-1084.
2. Kaiser HB, Naclerio RM, Given J *et al.* Fluticasone furoate nasal spray: a single treatment option for the symptoms of seasonal allergic rhinitis. *J Allergy Clin Immunol* 2007; **119**(6): 1430-1437.
3. Ratner P, Andrews C, van Bavel J *et al.* Once-daily fluticasone furoate* nasal spray (FF) effectively treats ocular symptoms of seasonal allergic rhinitis (SAR) caused by mountain cedar pollen. *USAN approved name. *J Allergy Clin Immunol* 2007; **119**(Supp 1): S231.
4. Avamys Summary of Product Characteristics.
5. Medical Design Excellence Awards 2008 winner. www.mdeawards.com Accessed on 9/12/08. Medical Design Excellence Award 2008 winner. The award is based upon descriptive materials submitted to the jurors; the jurors and the competition operators did not verify the accuracy of any submission or of any claims made and did not test the item to which the award was given. For further information please visit www.mdeawards.com

Code: AVS/FPA/09/39890/1 Date of preparation: January 2009

Allen & Hanburys
GlaxoSmithKline
Freephone 0800 221441
Fax 020 8990 4328
customercontactuk@gsk.com
customer contact centre
gsk GlaxoSmithKline

Chemist+Druggist
news + education + tools for the pharmacy community

Comment from the Editor

However complex it might be, technology is meant to make our lives easier. It should be a 'behind the scenes' enabler, helping us do our job more efficiently.

So why does the rollout of a modern national pharmacy IT infrastructure for England appear to be such a challenge?

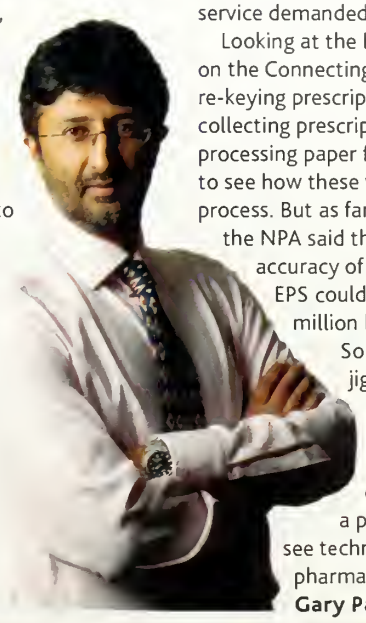
England's main pharmacy representative groups have made their position clear, as our exclusive (p4) story reveals. In their behind closed doors meeting with the DH, they cited a number of concerns about the rollout of EPS. These range from the lack of clear benefits of EPS release 1 reported by contractors, to the inability of the system to allow pharmacists to change the dosage syntax.

They also blamed a lack of information about the development of EPS release 2 and argued that system suppliers needed to do more to deal with reported faults.

There may be justification for all of these issues, but are there any other issues that need to be addressed?

For pharmacists operating at the frontline, the overwhelming priority is to quickly and safely dispense the ever-increasing volume of prescriptions. But will EPS, as it currently stands, really make any significant difference to the work processes in the average dispensary?

> "Will EPS really make any difference to the work processes in the average dispensary?"



Will it ultimately free pharmacists to deliver the clinical service demanded by our paymasters?

Looking at the benefits for dispensing staff listed on the Connecting for Health website – time saved re-keying prescription information, time saved collecting prescriptions from surgeries and time saved processing paper forms at the month end – it's not easy to see how these will radically change the dispensing process. But as far back as October last year, PSNC and the NPA said they were concerned about the accuracy of the official statistics that claimed EPS could save pharmacists more than six million hours over three years.

So what is the missing part of the jigsaw? In all the discussions, little has been said about repeat dispensing. Giving pharmacists complete responsibility for managing 80 per cent of their workload must be a priority. And maybe then we would see technology being used to make pharmacists' day job easier.

Gary Paragpuri, Editor

Contents

C+D TABPI Awards 2008 Winner for news coverage

Emergency EPS summit blames IT firms...

EXCLUSIVE Pharmacy bodies say system suppliers must do more to resolve problems

Zoe Smeaton

System suppliers are not responding well enough to pharmacy contractors reporting IT faults, according to the Department of Health and pharmacy representative bodies.

The comments were made during an emergency meeting last year called by five pharmacy bodies (PSNC, RPSGB, NPA, CCA and AIMp) with the Department and Connecting for Health to discuss concerns over the electronic prescription service (EPS).

At the time, all refused to comment on whether the meeting had restored confidence in the project. But action points from the meeting, obtained by C+D under the Freedom of Information Act, reveal widespread concern about IT suppliers.

Connecting for Health pledged to help improve supplier helpdesk facilities, and the pharmacy bodies promised to "facilitate their members to exert more pressure on system suppliers to improve their performance".

It was noted that as release 2 was being developed while release 1 was rolled out, "system supplier performance on release 1 might have ceased to improve owing to their focus on release 2".

During the meeting, the pharmacy bodies also said they did not feel sufficiently informed about the development of EPS release 2.

Connecting for Health responded that it would review membership of the EPS User Group and Implementation Board and liaise with PSNC.

The agency also agreed to set up a meeting to address the issue of communications from the user group and board.

Attendees said they would arrange another meeting for February or March, but the DH could not confirm the date of this meeting.

What was said behind closed doors

- **Contractors don't persist in resolving EPS problems because there are "no clear benefits" associated with release 1**
- **Contractors do not receive good enough responses from suppliers when reporting faults**
- **Suppliers may have ceased to improve release 1 systems due to focus on release 2**
- **Pharmacy bodies do not feel sufficiently informed about the development of release 2**
- **Release 2 is not a 'big bang' but about pharmacists making their own business decisions**

... but suppliers refute allegations

System suppliers have hit back at claims they are not responding well enough to faults reported with EPS.

Simon Driver, managing director at Cegedim Rx, said the company's analysis of customer service showed this was "simply not the case". And he questioned whether all problems were reported to suppliers in the first place.

Martin Jones, commercial manager at Positive Solutions, said it seemed to be a "standard response" from pharmacy bodies that suppliers must be to blame for EPS problems. But many were caused by the GP programmes or other systems the pharmacy suppliers could not control, he added.

Pharmacists also backed the suppliers. Sandeep Dhami of Buckinghamshire LPC said where EPS problems were encountered: "Usually the issue is not with suppliers but the NHS spine, which is still taking a long time to pull down prescriptions." And David Croucher, of Niton Pharmacy, said he had been "absolutely delighted" with his supplier's response to any problems. **ZS**

RPSGB sets date for 'title' SGM

The RPSGB will hold a Special General Meeting (SGM) on April 19 to discuss who should be allowed to use the title of pharmacist from spring 2010.

The SGM, to be held at the Park Plaza Riverbank Hotel in London, was triggered by a 30-signature petition by members opposed to the Society's response to the draft Section 60 Order.

The Society came under fire after recommending the title 'pharmacist' be restricted to those registered with the GPhC.

The Society announcement coincides with the Institute of Pharmacy Management's (IPM) response to the Section 60 Order, which recommended the restricted title should be 'registered pharmacist' or 'licensed pharmacist'.

Speaking to C+D, IPM general secretary Howard McNulty said the title 'pharmacist' should be reserved for those who join the professional leadership body.

He said: "What is a pharmacist? At the moment [the Medicines Act] says it's a member of the RPSGB... what we're saying is, why do you need to change that?" Mr McNulty said many in the profession not governed by the GPhC would lose out under the Society's proposal. **CC**

The right to call yourself a pharmacist will be debated at an RPSGB special general meeting on April 19

Scotland 'not consulted'

Scottish pharmacists have condemned moves to extend statutory regulation of pharmacy technicians across Great Britain without, they say, proper consultation.

Draft legislation laid before the Scottish Parliament and Westminster earlier this month had not considered the impact on the devolved nation, Community Pharmacy Scotland (CPS) said.

Legislation not yet in force covers England and Wales. The update includes Scotland and could realise statutory regulation by the summer.

CPS told C+D: "We feel it's moved from England and Wales to Great Britain without proper consultation [about Scotland]." **JR**

Photos: Google

Pharmacies across the country were literally put on the map last week as web giant Google released its Street View images of the UK. The feature, available on the Google Maps website, gives street-level panoramic photos of most roads in 25 cities and towns across the country. The images allow virtual visits to most pharmacies in the featured locations, as well as traditional bird's eye view maps and satellite imagery. Find out if you've been snapped – go to www.maps.google.co.uk and type in your postcode

Rates rise 'may lead to closures'

Increases in businesses premises taxes could lead to the closure of pharmacies, contractors have warned.

Both multiples and independent representatives have slammed the government's 5 per cent hike in business rates, due to come into effect next week, as "bad news" and "complete madness".

Numark director of professional services Mimi Lau told C+D: "Ultimately, this could lead to closures and bad news for patients who rely on pharmacies in all locations."

Co-operative Pharmacy MD John Nuttall said the rates rise would add further pressure during a difficult financial time for pharmacies. The taxes should not be increased above the level of inflation, he added.

The new business rate is based on September's inflation, which was at a 17-year high of 5 per cent. However, this week the indicator fell below zero for the first time in half a century.

Alliance Boots health and beauty chief executive Alex Gourlay branded the rise "complete madness" at a retail conference this week.

The NPA "strongly opposed" any additional tax burdens on members' businesses, spokesperson Neal Patel said.

The comments add pharmacy's weight to retailer calls for a freeze on business rates ahead of the planned rise implementation date of April 1. **JR**

Can your business cope with the rise?
jrichardson@cmpmedica.com

UniChem to cut up to 220 jobs

UniChem could make nearly 5 per cent of its UK workforce redundant in response to hostile trading conditions hitting the wholesale sector.

Up to 220 jobs are at risk as part of a restructuring programme announced by the wholesaler this week.

UniChem said the proposed cuts reflected a toughening market and were essential to the long-term future of the business.

The move will not impact on service to pharmacists, the wholesaler stressed.

The wholesaling market has been under heavy pressure after a spate of manufacturer-led supply deals. Each distribution deal results in less money for wholesalers, an industry insider told C+D. The job cuts were not a result of the credit crunch, UniChem said.

The wholesaler is in discussions with affected staff and trade union representatives over the cuts.

Workers will be redeployed within the company wherever possible and UniChem will also offer employees voluntary redundancy.

Warehouse and head office staff are most at risk of job losses. UniChem employs over 5,000 staff in the UK. **MG**

News in brief

Cat M 'more stable'

Category M is now a "much more stable environment" for contractors, a generics expert has said in response to the newly published April tariff. Actavis commercial director Michael Cann told C+D: "Various groups have lobbied for stability and I think the government has delivered that now." Look out for the Category M Barometer in next week's C+D.

CCA leavers

Two of the CCA's senior management team are leaving the organisation, chief executive Rob Darracott has confirmed. Georgina Craig, head of communications and partnership, and Neil Slater, head of operations, are leaving the trade body. Mr Darracott would not comment on the reasons for their departure.

MUR increase

The number of medication reviews carried out in Wirral has increased eightfold over four months as a result of interprofessional working under an RPSGB-led scheme. Patients were referred to either community pharmacy MURs or clinical reviews by PCT practice pharmacists.

RPSGB guide

Good practice guidance for diagnostic testing and screening services has been published by the RPSGB. The guide can be downloaded from www.rpsgb.org/pdfs

MHRA proposals

MHRA proposals to restrict wholesale dealer's licence exemptions would negatively impact patient care and be anti-competitive and illegal, pharmacy groups have warned. www.chemistanddruggist.co.uk

Counterfeit information

The MHRA and RPSGB have teamed up to produce patient guidance, to be distributed by pharmacies in prescription bags, on counterfeit medicines. The postcard-sized leaflets cover what patients should do if they suspect they have been given counterfeits and can be downloaded from www.rpsgb.org.uk.

Clinical briefs

Eczema on the rise

The incidence and prevalence of eczema in England is increasing. A database of more than nine million patients found incidence had increased by 40 per cent between 2001 and 2005, with the number of eczema-related prescriptions increasing by around 57 per cent.
www.jrsm.rsmjournals.com

Free coeliac posters

Pharmacists have been encouraged to order free posters aimed at highlighting the incidence of coeliac disease in the UK. The poster campaign, run as part of Coeliac Awareness Week (May 11 to 17), lists symptoms and encourages undiagnosed patients to seek advice. To order a free poster call 0800 783 1992 or email info@juvela.co.uk.

Nice guideline stands

The Nice guidance on osteoporosis will stand until due for revalidation, the High Court has ruled. A judicial review in February had found that Nice acted unlawfully by not releasing the economic model on which it based its decision.
www.nice.org.uk

Alcohol resource works

A toolkit for pharmacists has helped raise alcohol awareness, a pilot scheme has found. The pack, which contains booklets, posters and scratch cards, was given to pharmacies in three Lancashire PCTs as part of the Know Your Limits campaign.
www.chemistanddruggist.co.uk

BMI a predictor of death

BMI is a strong predictor of overall mortality, a meta-analysis of 57 studies has found. Looking at more than 894,000 patients, the study found those outside the optimum range of 22.5-25kg/m^2 had a decreased median survival.
www.lancet.com

Schizophrenia guideline

Nice has released an updated guideline on the management of patients with schizophrenia. The guideline, which includes the use of atypical antipsychotics and non-pharmacological therapies, recommends health professionals ensure they are aware of these patients' needs.
www.nice.org.uk

Multiples commit to tackling stress at work

Firm pledge to cap hours and guarantee breaks in response to C+D and PDA survey

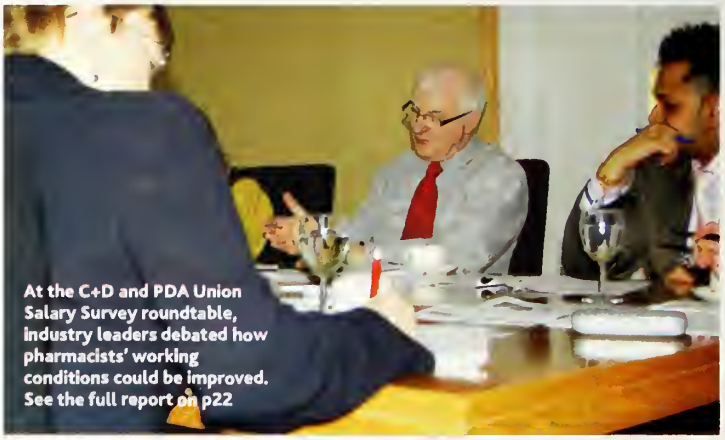
Jennifer Richardson

The UK's largest multiple pharmacies have stepped up their commitment to tackling work stress, after the C+D and PDA Union Salary Survey revealed plummeting morale (C+D, March 21, p4).

Co-operative Pharmacy superintendent Janice Perkins has pledged to "tackle the challenging issue of rest breaks for pharmacists" and to ensure that none work more than a 48-hour week.

She has also asked all employee pharmacists to highlight concerns via a dedicated email address, which will feed into the RPSGB's Workplace Pressures campaign.

Asda Pharmacy superintendent John Evans told C+D he "insisted" pharmacists took rest breaks. Pharmacists needed to make better use of pharmacy staff to avoid increasing workloads, he added.



At the C+D and PDA Union Salary Survey roundtable, industry leaders debated how pharmacists' working conditions could be improved. See the full report on p22

"Pharmacists have got to use their heads, not their hands," he said. Asda also insisted pharmacists did not under-spend on team hours, Mr Evans stressed.

Pressure from store managers who lacked understanding of pharmacy issues was "undoubtedly" an issue some pharmacists faced, as the Salary Survey suggested, but Mr Evans said Asda employees were "told quite clearly that the pharmacist has the final say on pharmacy issues".

Both Lloydspharmacy and Boots said they had invested heavily in management training and employee support, in response to their own employee satisfaction surveys.

Pharmacist struck off for stealing temazepam

A stressed Wigan pharmacy manager who stole benzodiazepines has been struck off.

Anne-Marie Dove admitted taking temazepam tablets without permission from the WA Salter Ltd pharmacy in Wigan where she worked.

Ms Dove, of Ince, Wigan, suffered problems with "stress and alcohol consumption", for which she was receiving help, an RPSGB hearing was told.

The disciplinary panel ruled Ms Dove had put patients at risk by failing to declare she was not fit to practise when aware of her problems.

Ms Dove, who did not attend the hearing, first acknowledged having issues with stress and alcohol consumption in February 2007, the panel was told.

In July 2007, she admitted taking medicines from the dispensary because she still needed help for her condition.

Ms Dove failed to report this to the Society or any appropriate person earlier, the panel heard.

She was said to have supplied herself an unknown quantity of temazepam 20mg tablets and diazepam 5mg tablets.

Ms Dove has three months in which to appeal. **UKL**

Lloydspharmacy defends advance EHC supply

Pharmacists, family planning experts and the Department of Health have joined Lloydspharmacy to defend its service to provide the morning-after pill in advance via the internet.

Several national newspapers highlighted fears that the service would encourage unprotected sex.

Lloydspharmacy has teamed up with online prescriber DrThom to supply up to three doses of the emergency hormonal contraceptive (EHC) pill, before the customer needs it.

Women fill in an online questionnaire, which is reviewed by DrThom's doctors before they prescribe advance supply of EHC – dispensed by Lloydspharmacy and despatched to the patient by post.

Shadow health secretary Andrew Lansley said EHC should only be available in person. "Wider availability would run the risk of encouraging unprotected intercourse, with the attendant risk of sexually transmitted infections," he said.

But Lloydspharmacy said safeguards included that DrThom's doctors would address frequent requests; customers could speak to them via email or telephone; and they would "not knowingly" serve under 18s.

And the RPSGB, DH and British Pregnancy Advisory Service all backed the service. Pharmacists were already able to use their professional discretion to provide advance EHC, they said. **JR**

New Freederm Gel 10g is now here!

- **Freederm gel** - the best selling over-the-counter spot treatment* previously only available as a 25g P medicine - is now joined by a smaller 10g GSL self-selection pack
- **Freederm gel** is the only OTC spot treatment with an anti-inflammatory - nicotinamide

Nothing treats spots like Freederm gel

New Freederm clip strip

For brilliant standout and maximum pick-up power

Ask your Dendron representative for more details

Freederm Trademark and Product Licence held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Indications:** For the topical treatment of mild to moderate inflammatory acne vulgaris. **Directions:** For adults, children and the elderly: Apply to the affected area twice daily after the skin has been thoroughly washed with warm water and soap. Enough gel should be used to cover the affected area. If there is no improvement within 12 weeks, patients should seek advice from a doctor or pharmacist. For cutaneous use. **Contraindications:** Not to be used in cases of sensitivity to any of the ingredients. **Precautions:** Not suitable for patients with severe acne. For external use only and to be kept away from the eyes and mucous membranes, including those of the nose and mouth. If excessive dryness, irritation or peeling occurs reduce the dosage to one application per day or every other day. Vitamin B derivative requirements, such as nicotinamide, are increased during pregnancy and infancy. Nicotinamide is excreted in breast milk. As with all medicines, care should be exercised during the first trimester of pregnancy. **Side-effects:** The most frequently encountered adverse effect reported is dryness of the skin. Other less frequent adverse effects include pruritus, erythema, burning sensation and irritation. **Freederm Gel Legal category:** GSL **Packs:** 10g, RSP £4.99 (£4.24 exc VAT). PL 0173/0187 **Freederm Treatment 4% w/w Gel Legal category:** P **Packs:** 25g, RSP £8.95 (£7.61 exc VAT). PL 0173/0398 **Revision Date:** March 2009. *IRI Infoscan Data. All outlets MAT £ Feb '09.

Dispensary TALK

Should the title pharmacist be restricted to those registered with the GPhC?

"Yes, I agree with that. It's the status quo, and things are fine the way they are."
Raj Radia, Spring Pharmacy, London

"I would say yes. If you look at it from a patient care point of view, how do you know the pharmacist is registered in this country?"
Raj Patel, Mount Elgon Pharmacy, London

WEB VERDICT:

Yes 30%
No 70%

Armchair view: The RPSGB's Special General Meeting over the [illegible] set to be [illegible] seven in 10 respondents [illegible] restricting 'pharmacist' to those [illegible] with the GPhC.
Next week's question: How well has your system supplier responded to EPS problems?
www.chemistanddruggist.co.uk

Why were pharmacists the last to know about changes to children's cough and cold medicines?
See page 12

GPs steal limelight in white paper responses

Dispensing doctor issue dominates feedback to landmark paper for pharmacy

Andrew Alexander/Max Gosney

Protests from dispensing doctors dominated official feedback to the pharmacy white paper, government figures have revealed.

Nearly 63,000 responses centred on now abandoned proposals to curb GPs dispensing powers – almost 97 per cent of all feedback to the document.

Pharmacy leaders voiced regret that a paper outlining landmark reforms for the sector in England had been sidetracked by a GP issue.

David Pruce, RPSGB director of policy and communications, said: "It's really unfortunate. Dispensing doctors' existence was being threatened by a part of the white paper so it's kind of not surprising they responded in such volume."

In comparison, just a few hundred pharmacists responded to consultations on the responsible pharmacist and changes to stoma appliances, figures released by the Department of Health revealed. The lower numbers showed people are more likely to speak out against something negative, Mr Pruce said.

97 per cent of responses were about GP dispensing power

The decision by the Dispensing Doctors' Association (DDA) to hire a top PR firm had also boosted the level of GP feedback, he added.

DDA chief David Baker said the move was "money well spent" as the strength of doctor's protest had persuaded ministers to abandon restrictions on dispensing.

The issue should not have been mixed up in a document on boosting pharmacists' NHS role, Mr Baker said. Continued co-operation between the sectors was an ongoing priority, he stressed.

The pharmacy white paper had proposed changes that would have stopped doctors dispensing where there was a pharmacy within a mile of their practice. The proposals were scrapped by the government last December in response to heavy opposition from GPs.

What can pharmacy learn from GP tactics?
mgosney@cmpmedica.com

It's no to OTC sales by dispensing doctors

The government has ruled out allowing dispensing doctors to sell OTC medicines, C+D has learned.

The decision means pharmacies near to such practices no longer stand to lose up to £24 million in sales, which the Department of Health predicted could be the impact of the proposals in the pharmacy white paper consultation (C+D, September 20, p6).

Rejection of the plans came to light after the opposition parties clashed on the topic over the weekend. The Liberal Democrats dubbed the proposals "a potentially dangerous move", while the Conservatives said they contained "some logic".

But a DH spokesperson told C+D: "We currently have no plans to change the arrangements by which doctors provide medicines to patients. This includes allowing GPs to sell OTC medicines."

The NPA and Numark hailed the decision as evidence of government confidence in pharmacy.

The decision to rule out the OTC sales had been implicit in December's rejection of new restrictions on doctor dispensing, the DH spokesperson claimed. **JR**

Avicenna eyes more growth as profits rise

Avicenna has set itself further ambitious membership expansion targets after reporting a 16th successive year of financial growth.

The buying group said a surge in membership numbers, from 700 to over 1,000 in the past year, had contributed to pre-tax profit growth of more than 8 per cent, to almost £1.3 million for 2007-08.

CEO Salim Jetha told C+D the company was aiming for a further increase of 300 to 400 members in 2009-10. However, he claimed Avicenna would shift its emphasis from recruitment to building closer relationships with existing members.

The buying group's success was due to members' "crucial" loyalty, with ongoing support for its preferred suppliers and services, Mr Jetha added. This would also be an important addition to Avicenna's own efforts to recruit from its rivals, he said. "Our members are our biggest ambassadors."

Avicenna had "two or three" acquisitions in the pipeline, Mr Jetha also revealed. And he believed the economic downturn could provide increased opportunities. Mr Jetha said: "We are looking at much, much bigger acquisition projects than we have done in the past, on a much larger scale." **JR**

BACK IN STOCK

HELP YOUR CUSTOMERS SEE THE REAL RESULTS

THE ONLY MEDICALLY PROVEN SOLUTION TO HEREDITARY HAIR LOSS

Extra Strength Solution –

- Stops hair loss in **4 out of 5 cases**
- Results visible in as little as **8 weeks**
- **P - Pharmacy Only licensed**

Minoxidil

Regaine For Men Extra Strength Product Information:
Presentation: Cutaneous solution containing Minoxidil 50mg/ml (5% w/v). **Uses:** Treatment of alopecia androgenetica in men aged 18 to 65. **Dosage:** 1ml twice daily to affected areas of scalp. Maximum dose 2ml in 24 hours. **Contraindications:** Hypersensitivity to ingredients. Hypertension. Scalp abnormality. Shaved Scalp. Occlusive dressings on scalp or other topical medications. Also contraindicated for use in women. **Precautions:** For external use only on normal healthy scalp. Wash hands thoroughly before and after application. Avoid inhalation of spray mist and contact with eyes or sensitive surfaces. Stop use and see doctor if hypotension or other cardiovascular symptoms of systemic absorption develops. Patients with cardiovascular disease or arrhythmia to contact physician before use. **Interactions:** Topical drugs such as corticosteroids, tretinoin, dithranol or petrolatum. **Pregnancy and lactation:** Not recommended. **Side effects:** Hypertrichosis. Local erythema. Itching. Irritation. Dry skin/ scalp flaking. Exacerbation of hair loss. Rarely hypotension. **RRP (ex-VAT):** *Regaine for Men Extra Strength*- Single pack £29.08, Triple pack £58.19. **Legal category:** P. **PL holder:** McNeil Products Ltd, Foundation Park, Maidenhead, Berks, SL6 3UG **PL numbers:** PL 15513/0148 **Date of preparation:** February 2009.

Version no. 04263

Conference bites

No Boots Phoenix link

Phoenix chief executive Paul Smith has told C+D he is not aware the company owning Alliance Boots is interested in buying the Phoenix group. As far as he was aware there had been "no contact" on the matter between the two groups. The comments came after the Financial Times reported KKR, which owns Alliance Boots, had made an approach to acquire the wholesaler.

Time for change

The profession must embrace change and move towards a greater service offering if it is to survive, Numark interim managing director John D'Arcy has warned. Opening the conference in Dubai, Mr D'Arcy said the challenge for pharmacy going forwards was to "up the ante" and get more and more services commissioned. See www.chemistanddruggist.co.uk

Diabetes opportunities

Pharmacists should make the most of their diabetic patients, Numark conference delegates heard. Roche Diagnostics said a diabetes patient was worth up to £4,000 per year for a pharmacy, and suggested tactics such as screening and related services including foot and eyecare.

Numark twitters

C+D is using Twitter to report live from events and here's a sample of new posts from the conference. More at www.chemistanddruggist.co.uk/news.

Monday am: Early start in Dubai. Numark MD John D'Arcy warns that change is upon us.

Monday pm: Heading into the desert in a 4x4 for camel riding, belly dancing and 'sand boarding', whatever that is.

Tuesday: Busy morning hearing how pharmacists can benefit from the credit crunch. Filming of delegates abandoned as we are forced to take a break from the heat.

Wednesday: Final interview with MD John D'Arcy ahead of gala dinner.

See Zoe Smeaton's video of the Numark conference in Dubai at www.chemistanddruggist.co.uk

PCTs breach guidelines

Type 2 diabetes patients are being disadvantaged by having their test strips limited

Zoe Smeaton

PCTs have been imposing rules that breach guidance on patient care to cut costs, Numark members reported at the group's biennial conference in Dubai.

Contractors said some PCTs had been limiting the number of blood glucose testing strips for type 2 diabetes patients to one pack of 50 per year. This goes against advice issued by diabetes experts that many of these patients should test at least three times per week.

And in some cases the box of strips would have expired before the end of the year.

Chris Forster, of Fairmans Chemist, told C+D that one surgery in his local area had "knocked testing strips off" prescriptions altogether for type 2 diabetes patients, citing PCT guidance. Mr Forster said: "Sales of strips went to almost zero as people can't afford them because it's quite a deprived area."

Mr Forster said while there had been some over-use of testing previously, perhaps encouraged by pharmacy selling the strips, he hoped a better compromise could be reached.

Numark member Sanjay Doegar, of Ruislip Manor Pharmacy, said he had also seen PCTs limiting the number of testing strips allowed. He said when patients had used their quota, they were simply not allowed anymore.

Mr Doegar added that the problem extended to other therapy areas too, such as in care for eczema where government guidelines recommend patients should be able to choose which emollient to use. Mr Doegar said in one PCT he had worked in, only one emollient was ever allowed to be prescribed to save on costs.

Chris Forster has witnessed sales of strips plummet as patients can't afford to buy them

Is your PCT breaching guidelines?
zsmeaton@cmpmedica.com

Credit crunch is an opportunity for independents

The credit crunch could be a positive opportunity for independent contractors, experts have said.

Delegates at the Numark annual conference in Dubai heard that for independents marketing their services well, the recession could be a real chance to boost business.

Mark Humble, a senior customer development manager at McNeil, said independent pharmacies were agile businesses that could upskill and adapt to cope with the times. Marketing locally could help independents to outcompete other retailers, he added.

Umesh Modi, a specialist pharmacy accountant at Silver Levene, agreed: "The credit crunch is an opportunity for a lot of pharmacists to actively sell their services and build customer loyalty." He said with the economic downturn he suspected a lot of people would not be visiting large shopping centres and so might be more drawn to local shops. "We can see that as an opportunity to buy into pharmacy services," he said. **ZS**

Mixed views on Numark merger

Former Nucare members attending the Numark conference in Dubai had mixed views on the success of the merger between the two buying groups last year.

Several Nucare members said they were currently using up old share incentive points and had not yet decided whether to stay with the new group permanently. But others said attending the conference had persuaded them to stay with the new group.

Joanne McMurray, of Church Street Pharmacy in Shropshire, a former Nucare customer, said she didn't feel enough was done at the time of the merger for Nucare customers. She said: "It only really works if you are using Phoenix as your main wholesaler."

Ms McMurray added that she would need to work hard to make Numark work for her, but said the conference had proved invaluable.

One former Nucare member told C+D the conference had settled their doubts about staying with the group by highlighting the benefits of membership.

So far around 200 of the 700 former Nucare members have signed up to the merged group, which now represents 2,012 independents. Interim managing director John D'Arcy said he believed Numark should be the group of choice to help independent pharmacists in service delivery and as a buying group, but independents had to decide for themselves, based on Numark's offering. **ZS**

new

a turning point for weight loss

real evidence – **alli** is orlistat 60 mg, the first and only non-prescription weight loss treatment licensed throughout Europe

real help – adding **alli** to a reduced calorie, lower-fat diet helps users lose 50% more weight. So for every 2 lb users lose through their own efforts, **alli** helps them lose 1 lb more. **alli** provides a capsule and a support programme.

real benefits – **alli** brings positive change to customers and the opportunity for you to recommend with confidence.

orlistat

start the conversation

find out more at www.alli.co.uk

gsk GlaxoSmithKline

MyPharmAssist.co.uk The Online Pharmacy Community

Product Information **alli** 60 mg hard capsules (orlistat). **Indication** Weight loss in adults BMI ≥ 28. **Dosage** *Adults (18 or over)* One capsule within an hour of each of three main meals. Max 3 caps/day for up to 6 months. Use with lower fat mildly hypocaloric diet. If no weight loss within 12 weeks refer to HCP. Diet and exercise should start prior to treatment. **Contraindications** Hypersensitivity to ingredients, concurrent treatment with oral anticoagulants or ciclosporin; chronic malabsorption syndrome; cholestasis; pregnancy; breast-feeding. **Special warnings and precautions** See HCP if on amiodarone or medication for hypertension, hypercholesterolemia or diabetes as control of these conditions may improve necessitating alteration of therapy. Risk of GI symptoms increases with fat consumption. Take [illegible] at bedtime. See GP if rectal bleeding. Oral contraceptive may be reduced if severe diarrhoea, use additional [illegible]. **Drug interactions** Ciclosporin, oral anticoagulants, [illegible] vitamins, acarbose, amiodarone. **Pregnancy and lactation** Do not use during pregnancy or lactation. **Side effects** See SPC for [illegible]. Predominantly gastrointestinal e.g. oily stools, urgency, [illegible], mild and transient, risk reduced by low fat consumption. Hepatic [illegible], cholelithiasis, abnormal liver enzymes, anxiety, hypersensitivity reactions including anaphylaxis, bronchospasm, angioedema, pruritus, rash and urticaria, bullous eruption. **Legal category** P. **Marketing Authorisation Holder** Glaxo Group Limited, Greenford, Middlesex, UB6 0NN. **MA Number** EU/1/07/407/007 & 009. **Pack size and RSP** 42s £32.95, 84s £49.95. **Last revised** November 2008.

Why were pharmacists the last to know when the government decided to ban cough and cold remedies for children last month? **Gavin Atkin** examines a communications failure

A new cold war

The news bulletins on February 28 came as a big surprise to many in pharmacy. Newsreaders and headlines announced that many popular cough and cold remedies were to be banned for the under-sixes, and that pharmacists were to offer new advice on their use in six to 12-year olds.

It was probably the biggest change in the rules for children's treatments since the first edition of the Children's BNF or the ending of the use of aspirin in children, but no-one had told community pharmacy it was about to happen – and now it was out the RPSGB and the NPA had their work cut out to respond.

The announcement met with widespread anger from pharmacy, not least because it had been similarly unprepared only 12 months before, when the Daily Mail led with news that cough and cold medicines would be banned in the under-twos.

At that time, an MHRA official told C+D the incident had "concentrated the mind" on improving communications, and many in pharmacy began to hope things would improve.

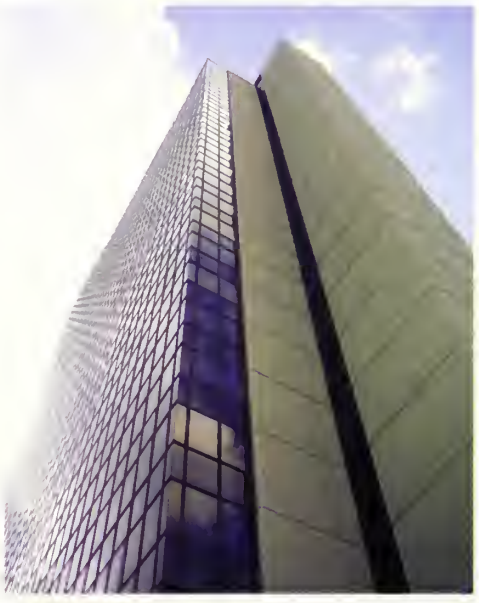
The MHRA did in fact plan an altogether more controlled release of information this time around. The agency's information for public health group manager Jeremy Mean told C+D that on Monday March 2 his organisation planned to contact the RPSGB and the NPA to ask them to attend a briefing on the Wednesday of that week, in time for them to communicate the new advice to their constituency – but, as we now know, the plan broke down.

The press were to have been invited to attend a briefing also on the Wednesday, with the information under embargo for release to the public on the Thursday.

Press embargoes are well understood in the news world. An organisation or company issues an announcement in advance of the official publication date, on the understanding that any news medium that publishes the story early will be denied early notice on any future stories.

The system works for both sides – news media employees have time to research their stories, while the organisations issuing the news retain some control over timing. In practice, embargoes are widely respected by journalists and they are a powerful tool that big city public relations operators use to manipulate the timing of news delivery every day of the year.

But the system breaks down if a journalist somewhere manages to pick up the story in question before the embargoed release is issued. And that is exactly what happened when a Daily Telegraph journalist learned of the MHRA's plans for cough and cold medicines in the two to 12 year age group before the plan went into action.



> "Angry and red-faced MHRA officials have been actively investigating"

The facts

- The MHRA has given manufacturers three years to gather evidence their remedies are effective in children.
- In the USA, the industry has been asked to conduct clinical studies on cough and cold medicines in children. Pharmacokinetic studies are expected to be completed by early 2010.
- Trials are due to start in the cold season of 2010-11.
- In the meantime, RPSGB director of policy and communications David Pruce has said that first-line treatments for coughs and colds in the six to 12 year age group should be the same as in children between two and six years (that is, they should be in line with the DH's Birth to Five document). Other medicines should be used as second-line treatments.

For a guide to give to your staff on cough and cold medicines in children, go to: http://tinyurl.com/ccb2mv
For the RPSGB guidance, which makes the pharmacist's legal and ethical position clear, see: http://tinyurl.com/cwof52

MHRA information for public health group manager Jeremy Mean is frankly very unhappy about it all: "We had a clear plan to give pharmacists in particular the information they needed based on the lessons learned when we announced the decision on children under two."

Journalists would be briefed to tell the public that this was not a safety issue, and communications would go to pharmacists so they would have the information before it reached the public. However, when the Daily Telegraph got hold of the leak and threatened to break the cough medicines story, there seemed to be little room for manoeuvre. "We took a positive decision that rather than let the Daily Telegraph run a potentially misleading story," says Mr Mean, "we would make a proactive announcement making the elements of the story clear."

It wasn't meant to happen this way, and it was particularly unfortunate that this meant it went out on Saturday morning, of all days. When asked, Mr Mean either won't or can't reveal the source of the leak, but there's no doubt that angry and red-faced MHRA officials have been actively investigating.

But even if everything had gone as planned, it has to be admitted that the MHRA wasn't going to give the NPA and the Society much time to act, if the task of inviting pharmacy leaders to the briefing was not going to begin until the Monday morning.

"We share the frustration of pharmacists that despite the best intentions of all concerned the perception can still be that 'pharmacists are the last to know'," an NPA spokesman told C+D. The organisation understands that in this case circumstances beyond the MHRA's control meant the planned briefing meeting to the NPA and others could not be convened. However, he also said that the NPA feels strongly that pharmacists must be briefed well ahead of the general public when at all possible, and that MHRA officials had agreed to an early meeting to discuss how similar issues should be handled in future.

In the real world, it's almost impossible for organisations to ensure there will never be another leak – for they simply have too many connections with the outside world. What's needed therefore is a plan to enable pharmacy to cope with big announcements that emerge outside office hours.

The news from the NPA is that it will take steps to enable it to respond to announcements whenever they arrive. It's a small step, but let's hope it's a sign that next time pharmacy's grandees will finally have their communications house in order.

Letters

Teva speaks out over tender decision

I was interested to read Terry Maguire (C+D, March 7, p15) say that for the Northern Ireland generics tender "major generic houses are withdrawing from the tendering process for reasons unclear". I know nothing about what other generics manufacturers have done, but Teva has always been completely transparent about why it never submitted a tender for primary care supply last year.

At the time we wrote to the NI health minister Michael McGimpsey to explain why the biggest generics manufacturer by market share in NI had declined to bid. In that letter, we said: "The reasons we declined to tender can be summarised as four problems:

· The invitation to tender as published was flawed and made it impossible to tender accurately, preventing us from submitting a compliant bid. We have a number of concerns on the tender documentation...

• The tender process as it stands has a number of negative implications for patient continuity and hence safety; and we believe that the current process will not achieve the cost savings desired...

• The proposals will not support a vibrant pharmacy industry in NI and could ultimately damage their interests and hence those of patients.

• If DHSSPS had engaged openly and proactively with stakeholders to seek help in achieving the goal of enhancing patient safety and getting the best value for money for NI's healthcare economy, a more robust, viable way forward could have been achieved."

However, we made it clear to the minister in the letter that Teva has no interest in influencing policy: our role is to provide, not decide. But after much thought on whether walking away from the business we would have won and therefore ceasing to supply our customers was the right thing to do, we decided not to attempt to make the unworkable workable.

We wrote to our customers at the time explaining our decision and the reasons. It might seem counter-intuitive to stand behind our customers by not trying to win their business under the tender proposal, but we believe the process that the DHSSPS proposed is not in the best interests of NI's pharmacy community or patients.

We also have the experience of the free market in the UK: the 2001 Oxera report on generic medicines said market forces achieve a highly competitive market.

Pharmaceutical manufacturers tender hundreds of times every day, in every pharmacy, through pressure of a diverse market. The UK enjoys the lowest generic medicine costs in Europe and the market-driven environment, with choice and bargaining power for the pharmacist, is the key reason for that situation. What we have always stressed is that we, alongside the PCC and other stakeholders, want to help the Department meet its aims of getting the best value and the best patient care. We asked the minister in July 2008 for a meeting to explain our [illegible] other more effective [illegible] achieve its aims [illegible] to have that meeting [illegible] participate with the DHSSPS [illegible] other stakeholders to find a way forward that delivers the Department's aims, but also takes into account the need to maintain a vibrant pharmacy industry.

Paul Williams, head of communications, Teva UK

Xrayser What's your view? haveyoursay@cmpmedica.com

Hello five-year degree, goodbye pre-reg

Proposals to scrap the pre-reg year (C+D March 21, p10) sound like an admission that this outdated apprenticeship isn't doing graduates or the profession much good.

It's debatable whether the pre-reg year has ever been a good idea. But its demise must be as much to do with the practicalities of giving ever increasing numbers of graduates a uniformly worthwhile experience via an ever decreasing number of potential employers, as with what this training could achieve.

> "The existing system must be at breaking point"

Pre-reg years vary tremendously, from truly career enhancing, confidence building, learning experiences, to a year spent as a shop assistant, or worse. My own experience came under the latter category, and nearly served to make me give up on pharmacy before my career had even begun. At the hands of a particularly vindictive tutor with one of the large graduate employers, my life was made a misery, my self-confidence destroyed and I learnt very little except basic survival skills.

But, enough about me; with graduate numbers predicted to increase by 50 per cent between 2006 and 2010, to nearly 3,000, the existing system must be at breaking point. Our new professional body and the GPhC will have enough on their hands in 2012 without placing, devising training programmes, keeping track of, and examining over 3,000 trainees.

Funding must also be an issue, with the current fee per pre-reg standing at over £18,000, this significant investment demands a decent return. The obvious answer, of course, is to keep all these clever 22-year-olds at university for another year. Universities have plenty of money to support more students. Except they don't, as last week's calls from vice-chancellors to put up student fees shows.

The theory is fine – graduates from the revamped degree in 2017 should be able to compete with the best in terms of clinical knowledge. They will easily be able to take forward the aspirations set out in the white paper, if they ever get the chance. Just don't expect the new breed to operate a till or help put stock away. And they certainly won't be in any position to start their own business.

These 23-year-old clinical experts will also be completely broke. The pre-reg year was never a great earner, but at least you could cover living expenses. Eighteen-year-olds from poorer backgrounds will think twice about landing themselves in this much debt, quite apart from committing themselves to five years of study.

With pharmacy undergoing the biggest upheavals in its history, nothing will be the same, but planning for such a future is fraught with difficulties. I only hope that when these super keen and highly skilled new pharmacists start to emerge in 2017 pharmacy practice offers the opportunities to utilise their skills, gain satisfaction and enjoy a rewarding career path.

Locum at Large What's your view? haveyoursay@cmpmedica.com

Why being a pharmacist should carry a health warning

The news that the Society is to investigate the subject of stress in the profession was welcome but does it go far enough? Do we not need to consider other health factors which can affect the ability of a pharmacist to perform his/her duties satisfactorily? What about long working hours, sleep deprivation, especially for those poor individuals who have to commence their duties at 6am or 6.30am in 100-hour pharmacies? What time do they have to get out of bed?

Probably any time from 4am onwards, perhaps after a busy previous day with limited opportunity for breaks and a sensible meal, often surviving on snacks and sandwiches. I know some locums who will work right through until closing time at 10.30pm, perhaps later at certain times. And then do a 12 to 13-hour day the next day. Although some employers will accept such working practices, the risk of error from a worn out pharmacist must be considerable, and what condition are they in to face perhaps a long drive home, a risk to themselves and other drivers and pedestrians?

Is it correct that pharmacists should be on their feet for 12 to 13 hours a day? I thought that female staff at one time had to be provided with facilities to sit down if they so wished. Under the old Shops Act I am sure that was so. Not now though, apparently. Is there any other part of the retail sector where staff work the sort of hours that pharmacy staff do? Surely, the dreaded 'Elf & Safety must rear its ugly head somewhere? Are these all matters to be considered if we are looking at public safety and the welfare of our members?

A recent report has considered the effects of constant late-night working on patterns of health and sickness levels, particularly on women. The incidence of breast cancer in female shift workers is much higher than in those who work normal, especially day-time hours, and may be linked to lower levels of melatonin in those who suffer from sleep deprivation. (The body needs melatonin and apparently makes most of it while we are asleep).

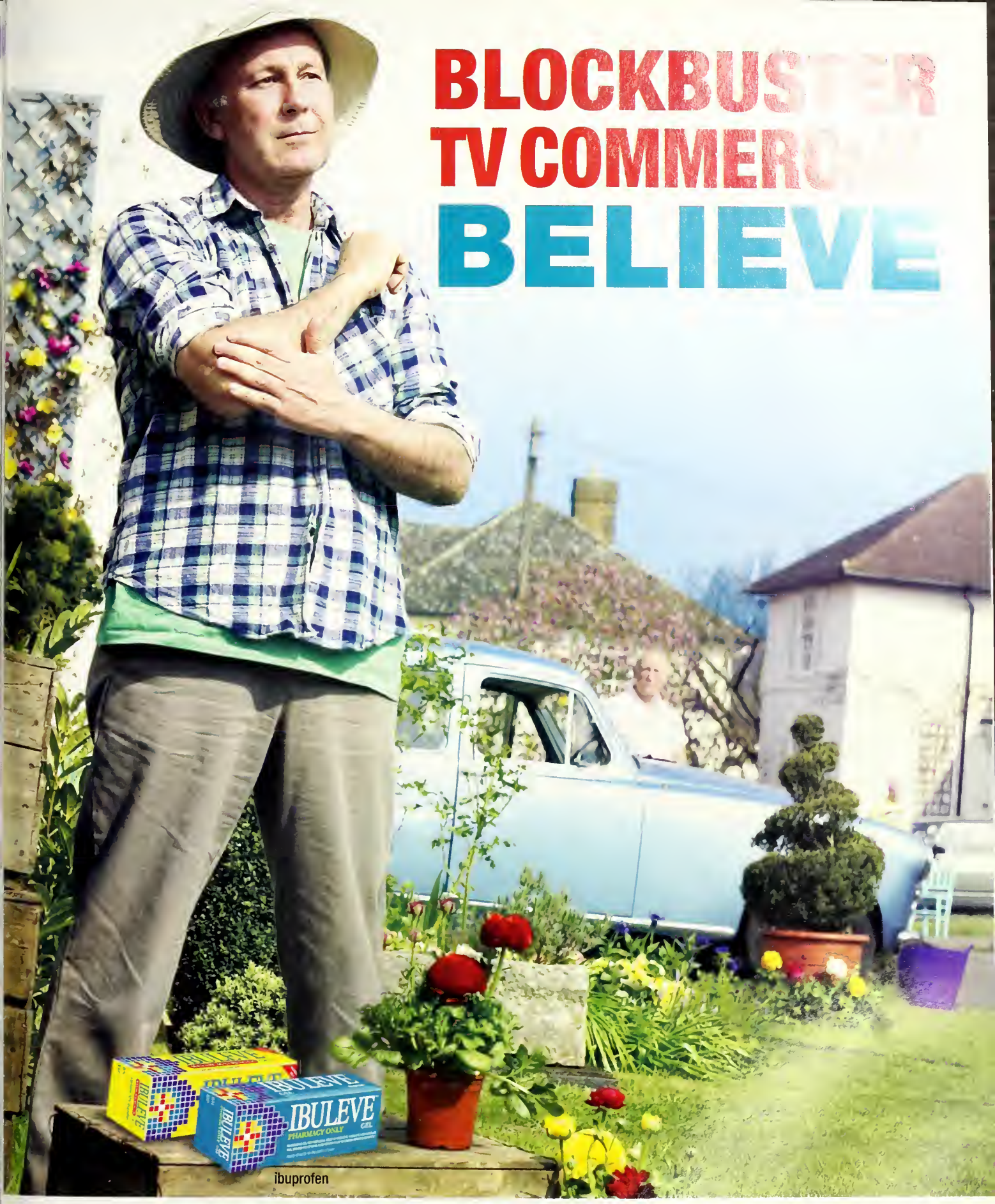
> "The incidence of breast cancer in female shift workers is much higher than in those who work normal, especially day-time hours"

Much of the above will not concern those who work a normal nine to six shift or who commence work at nine o'clock in the morning.

But there are certain practices in some pharmacies that I do not see repeated in other parts of the retail sector and I often wonder how or why some employers get away with it.

I have worked in them for many years, always without a break or a proper lunch hour and any suggestion that I should avail myself of the facilities of the staff canteen has always produced a negative response bordering on outrage. "Close the pharmacy – you must be joking!" I told one manager that in my time in the pharmacy I have to do three things: eat, drink and go to the toilet. He was not impressed and said that eating in the pharmacy was no more allowed than eating in the canteen. Not much sympathy there.

No-one expects pharmacy to be a bed of roses – I just wonder sometimes if the pendulum has not swung too far the other way.



With a powerful new campaign and heavyweight TV support, pain sufferers are singing the power of Ibuleve! Stock up now.

IBULEVE Trademark and Product Licence held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. Indications: For the relief of backache, rheumatic and muscular pain, sprains and strains. Also for pain relief in non-serious arthritic conditions. Directions: Lightly apply 2 to 5 cm of gel (50 to 125 mg ibuprofen) to the affected area. Massage gently until absorbed. Wash hands after use. Repeat as required up to three times daily. Contraindications: Not to be used if allergic to any of the ingredients, or in cases of hypersensitivity to aspirin, ibuprofen or related painkillers (including when taken by mouth), especially where associated with a history of asthma, rhinitis or urticaria. Not to be used on broken skin or where there is infection or other skin disease. Not to be used during pregnancy or lactation. Precautions: Not recommended for children under 12 years without medical advice. If symptoms worsen or persist, consult a doctor or pharmacist. Patients with asthma, an active peptic ulcer or a history of kidney problems should consult their doctor before use, as should patients already taking aspirin or other painkillers. Interaction with blood pressure lowering drugs may occur, but is very unlikely. Keep away from the eyes, nose and mouth. Keep all medicines out of the reach of children. FOR EXTERNAL USE ONLY. Side-effects: In normal use, side-effects are very rare, but may occasionally include hypersensitivity reactions, and in susceptible individuals renal and/or gastrointestinal side effects. Legal category: [P] Packs: Ibuleve Gel (PL 0173/0060) - 30g, RSP £4.25 (£3.62 exc.VAT), and 50g, RSP £5.95 (£5.06 exc.VAT). Ibuleve Maximum Strength Gel (PL 0173/0176) - 30g, RSP £5.45 (£4 64 exc VAT) and 50g, RSP £7.45 (£6.34 exc. VAT).

A Practical Approach

A facial sore

Eddie, a jobbing gardener, has looked after the garden of David Spencer, pharmacist at the Update Pharmacy, for several years. One day David happens to be at home when Eddie arrives. They are exchanging a few pleasantries before Eddie gets down to work, when David says: "What's that plaster on your face? Have you cut yourself shaving?"

"No," replies Eddie, "it's just a sore. It weeps a bit, so I cover it."

"Have you had it long?"

"A few months, I suppose. But it's not a problem. I expect it'll fade away eventually, like warts do, but at the moment I think it's spreading slowly."

"Does it hurt or itch?"

"Not really," Eddie replies.

David looks at the sore, which is a weeping, pinkish-brown flat scaly patch, rather lighter at the centre and with a thread-like border.

David says: "Eddie, I think you ought to see your doctor."

"Why? It's not causing me any trouble. If you like, I'll come down to your pharmacy and you can give me something to clear it up."

"I'm afraid I can't, because if it's what I think it is you'd need something on prescription or some other treatment. It's not serious now, but if you don't get it seen to I think it could be."

Questions

1. What is Eddie's sore likely to be?
2. How common is it?
3. What are the risk factors?
4. How is it treated?
5. What is the prognosis?
6. What advice can be given to help prevent it?

Answers

1. Superficial basal cell carcinoma (SBCC), a clinical subtype of basal cell carcinoma (BCC).
2. BCCs are the most common malignancy affecting white people and incidence is increasing. About 25 to 30 per cent of people can expect to develop the condition in their lifetime. It occurs more often in people over 40, but incidence in younger people is increasing.
3. Exposure to sunlight, particularly in childhood and adolescence, and long-term exposure – people with outdoor jobs are at greater risk; 'Celtic' complexion – fair skin, red/blonde hair, blue/green eyes; family history; immunosuppressive therapy.
4. Surgical: cryotherapy; curettage and/or cautery; excision – often done in primary care; in secondary care, Moh's surgery – diseased tissue is progressively removed and examined until all cancerous tissue has gone. Non-surgical: imiquimod or fluorouracil cream.
5. SBCC is usually not an aggressive form of BCC; it is rarely invasive and metastasises very rarely. Risk of recurrence is increased about 1.5-fold following a primary tumour, and recurrent tumours have poorer cure rates. Risk of malignant melanoma is increased.
6. Avoid UV exposure in susceptible individuals, particularly children and adolescents; avoid the midday sun; use high factor sun screens; wear wide-brimmed hats and do not expose the body to the sun.

Thank you to those readers who have suggested a scenario for Practical Approach – your Amazon vouchers are on their way to you. Email ideas to haveyoursay@cmpmedica.com

This article can help in the following CPD competencies: **G1a, G1d, G1q, C1f, C2a.** See http://tinyurl.com/68ox7b

C+D Clinical

Stomach upset or drug reaction?

The second article in a series on ADRs looks at drugs affecting the GI tract

60-second summary

If someone seeks advice on a GI problem why must you consider medicines they are taking?
Because between 13 to 20 per cent of all ADRs involve the GI tract.
What common GI symptoms could be drug-related?
Virtually all. Most drugs can cause nausea and vomiting. Constipation, diarrhoea, dyspepsia, GI ulceration, abdominal pain, dry mouth, taste disturbances and mouth ulcers may all be related to medicines.
What should you do?
This article explains when you might offer symptomatic treatment and when you should refer and/or suggest changing the drug.

Professor Janet Krska

Symptoms affecting the gastrointestinal (GI) tract commonly present to community pharmacists. They are also common adverse reactions to medicines (Table 1 overleaf). Between 13 and 20 per cent of all ADRs involve the GI tract, so it is important not to overlook this possibility when asked for advice.

Nausea and vomiting

Most drugs can cause nausea or vomiting, usually by central action on the chemoreceptor trigger zone or the vomiting centre, or locally on the GI tract by causing irritation or altering gastric motility. Often

CPD

This article (Module 1470) can help in the following CPD competencies: **G1a, G1c, G1e, C1a, C1b, C1d, C1j.** See http://tinyurl.com/68ox7b

Your Continuing Professional Development CPD

Reflect

Which drugs can cause constipation as a side effect? How can GI problems with NSAIDs be minimised? What advice should you give a patient taking bisphosphonates to reduce the risk of an ADR?

Plan

This article looks at drugs that can cause ADRs involving the GI tract. It covers nausea and vomiting, constipation, diarrhoea, dyspepsia and GI ulceration, advising on how to determine whether a drug is causing the problem and how to resolve it.

Most drugs can cause nausea or vomiting, but how do you determine if it is an ADR?

nausea reduces with continued use, but is nonetheless important because patients may stop taking medicines or lose doses through vomiting.

Cytotoxics, opioids and levodopa cause nausea or vomiting in most patients. SSRIs commonly cause nausea but it can, rarely, also be a withdrawal symptom. Nausea is a sign of toxicity with digoxin and theophylline, but is not otherwise a common side effect. Lithium can cause nausea early on in treatment, but in stabilised patients can indicate impending toxicity. High dose oestrogens, especially EHC, commonly cause nausea and vomiting, requiring a repeat dose if vomiting occurs within three hours of ingestion.

Symptomatic treatment

Anti-emetics may be given concurrently with highly emetic drugs, but are not usually required long term. Otherwise, patients should be informed about the possibility of nausea and that it is likely to reduce with time. In most cases, nausea can be minimised by taking medicines with food to reduce the rate of absorption, unless ingestion on an empty stomach is required.

As with any ADR, balancing the unpleasantness of the side effect against the benefit of continuing with the medicine is a matter for clinical judgement and the patient's personal choice. Clinical judgement is also required to advise about repeating doses if vomiting has occurred.

Constipation

Many medicines can cause constipation and consequent abdominal discomfort that is exacerbated by poor diet. Opioids are one of the commonest causes owing to reduced GI motility, reduced pancreatic and biliary secretion and increased absorption of fluids and electrolytes, resulting in small hard stools. Morphine causes constipation in most patients; constipation is common with dihydrocodeine, but less frequent with tramadol. Drugs with antimuscarinic effects reduce GI motility. Aluminium salts, present in some antacids, are constipating, as is iron, which is equally likely to cause diarrhoea. Many OTC products contain constipating constituents.

With opioids, constipation may not reduce with continued use, whereas antimuscarinic-induced constipation is not usually a long-term problem.

Symptomatic treatment

Opioid-induced constipation is often treated with a combination of a softening agent, usually lactulose, and a stimulant laxative. Often laxatives are started at the same time as highly constipating opioids if long-term treatment is anticipated.

As for any patient with constipation, advise a high fibre diet, increased mobility where possible and increased fluid intake.

TABLE 1: COMMON DRUG-RELATED CAUSES OF GI PROBLEMS

Symptom	Possible drug causes
Nausea and vomiting	Cytotoxic drugs, opioids, levodopa, digoxin, theophylline, lithium, high dose oestrogens, ACE inhibitors, antibiotics
Constipation	Opioids, tricyclic antidepressants, older antipsychotics, iron salts, antihistamines, anticholinergics, verapamil
Diarrhoea	Antibiotics, NSAIDs, orlistat, magnesium salts, iron salts, misoprostol, acarbose, metformin, leflunomide, bisphosphonates, laxatives
Dyspepsia	NSAIDs, SSRIs, aspirin, clopidogrel, ACE inhibitors, bisphosphonates
Oesophagitis	Bisphosphonates, tetracyclines
Dry mouth	Opioids, tricyclic antidepressants, older antipsychotics, antihistamines, antimuscarinics
Mouth ulcers	Cytotoxic drugs, SSRIs, NSAIDs, methotrexate, penicillamine, leflunomide
Hoarseness	Inhaled steroids
Taste disturbance	ACE inhibitors, calcium channel blockers, penicillamine
Weight/appetite loss	SSRIs, sulfasalazine, anti-dementia drugs
Weight/appetite gain	Tricyclic antidepressants, mirtazapine, venlafaxine, gabapentin, pregabalin, oestrogens/progestogens, corticosteroids

NB This list is not exhaustive. Always check the SPC if you suspect an ADR

For symptomatic relief a short course of a stimulant laxative or a bulk-forming agent can be recommended. However, if constipation persists with antidepressants or antipsychotics, alternative treatments may be needed.

Diarrhoea

Probably the most frequent cause of drug-induced diarrhoea is broad-spectrum antibacterial agents, which change the normal GI flora. This is not usually clinically important and, given the short treatment duration, usually requires no intervention. Clostridium difficile infections are, however, related to broad-spectrum antibacterials, especially following multiple courses. C difficile is an opportunistic bacterium that proliferates when normal flora are suppressed. It can release toxins leading to severe watery diarrhoea, abdominal pain, fever and ultimately serious or even fatal complications. Therefore, severe diarrhoea associated with antibacterial therapy requires immediate referral for investigation of stool samples to detect C difficile toxins.

NSAIDs can cause acute diarrhoea initially or may be implicated in colitis after several weeks or months of treatment.

Orlistat causes frequent oily stools, urgency, flatus and abdominal discomfort. Indeed, users regard these as signs of efficacy! Another potentially important cause of diarrhoea is misuse or simple over-use of laxatives.

Symptomatic treatment

Prolonged diarrhoea may result in loss of water and electrolytes, requiring rehydration. Loperamide may be suitable for immediate relief, depending on other medical problems and concurrent treatments but, generally, if diarrhoea is a feature of a new therapy it may reduce with continued use. Increasing the doses slowly may help to minimise the risks and, if diarrhoea is not tolerated, dose reduction may be required until it is resolved, followed by gradual increase.

Dyspepsia/GI ulceration

Dyspepsia is probably the most common symptom caused by NSAIDs and therefore, because of their widespread use, it is one of the most common ADRs. However, because

it is common it is often dismissed as 'normal'. Estimates suggest that at least 10 to 20 per cent of people taking an NSAID report dyspepsia, which may be accompanied by nausea. NSAIDs induce GI irritation by inhibition of the Cox-1 enzyme in the gastric mucosa.

Selective Cox-2 inhibitors have less risk of GI problems than non-Cox-selective drugs, but the pattern of ADRs reported to the MHRA is similar. Of the three most commonly used non-selective NSAIDs, ibuprofen carries the lowest risk of GI side effects, while diclofenac is less irritant than naproxen.

Information about the ADRs most commonly reported through the Yellow Card Scheme is available to download from the MHRA website (www.mhra.gov.uk) as drug analysis prints (DAPs). These are available for every drug. While it is not possible to compare the overall risks associated with different medicines using these analyses, the relative proportions of symptoms reported are comparable. For example, the overall proportion of ADRs affecting the GI tract with diclofenac is 34.4 per cent and for celecoxib 28.9 per cent.

Despite clear understanding of the association between NSAIDs and GI problems, the frequency with which patients are admitted to hospitals with GI bleeding or ulceration remains high. Ulceration and bleeding are not always preceded by dyspeptic symptoms, so may go undetected by the patient. Pharmacists can make a substantial contribution to reducing these admissions (see Box 1 online).

SSRIs and corticosteroids increase the risk of GI bleeding when given with NSAIDs, but may cause GI irritation themselves. Aspirin, even at anti-platelet doses, frequently causes dyspepsia. Enteric-coating does not protect against this. Clopidogrel also causes dyspepsia and GI bleeding and should not be substituted for aspirin in patients with high bleeding risk. Oesophagitis may be mistaken for dyspepsia. It too can be caused by NSAIDs, but is also commonly caused by bisphosphonates and tetracyclines.

Symptomatic treatment

Antacids can be recommended for short-term symptom relief, as can H_2 antagonists and omeprazole. However, it is essential to identify and address the underlying cause. The risk of ulceration or bleeding does not lessen with continuing treatment and symptomatic relief simply masks the ADR, so the appropriate course of action is referral.

Oesophagitis, commonly associated with bisphosphonates, can be minimised by swallowing the medicine with plenty of water and staying upright for at least 30 minutes. Indeed any solid dosage form, especially capsules, can cause discomfort if taken lying down or with insufficient water, particularly in patients with reflux disease. This simple administration advice may be enough but, if severe, the medicine should be discontinued. Analgesia may be recommended for acute relief of pain, using soluble or liquid formulations.

Professor Janet Krska is professor of pharmacy practice, School of Pharmacy and Biomolecular Sciences, Liverpool John Moores University.

A full version of this article, Module 1470, is available on C+D's website at www.chemistanddruggist.co.uk/update. It includes drugs affecting the mouth or causing other GI problems, a case study and further reading.

Your Continuing Professional Development

CPD

Act

- Read the full version of this Update article including further information on disorders of the mouth and other GI problems on the C+D website (www.chemistanddruggist.co.uk/update).
- Read the author's previous Update article: Reporting ADRs – Why Bother? (C+D, February 14, 2009, p19-22, or online at http://tinyurl.com/aubtue) if you have not already done so.
- There is more information about drug analysis prints and how to interpret them on the MHRA website at http://tinyurl.com/arp6f9.
- Update your knowledge of the GI side effects of NSAIDs by reading MeReC Extra 2007; 30: Cardiovascular and GI safety of NSAIDs, online at http://tinyurl.com/2pb5mk.
- Think how you can incorporate the information in this article into your patient consultations and MURs. Could you be more aware when advising on GI problems? Keep the table on common drug-related causes of GI problems in your MUR folder.
- Read about reporting ADRs and drug safety updates on the MHRA's new pharmacy web page at http://tinyurl.com/ctyzsa
- For further learning, the CPPE has a programme on Adverse Drug Reactions (ref 34678) available at www.cppe.ac.uk or on 0161 778 4024.

Evaluate

- Are you now confident in your knowledge of drugs that may produce ADRs involving the GI tract? Could you identify an ADR and would you know how to help a patient resolve it?

5 MINUTE TEST

What have you learned?

Test yourself in three easy steps

Step 1

Register for Update 2009 and you will receive a unique PIN number.

Step 2

Access the 5 Minute Test questions on the C+D website at **www.chemistanddruggist.co.uk/mycpd**

Step 3

Use your PIN to complete the assessment online or phone through your answers. Your test score will be recorded. If you successfully complete the 5 Minute Test online, you will also be able to download an RPSGB-approved CPD certificate. It's that simple.

Registering for Update 2009 costs £32.50 (inc VAT) and can be done easily at **www.chemistanddruggist.co.uk/update** or by calling 01732 377269.

Signing up also ensures that C+D's weekly Update article is delivered directly to your inbox free every week with C+D's email newsletter.

Get an RPSGB-approved CPD certificate for your portfolio when you successfully complete the 5 Minute Test online

Sign up for Pharmacy Update and win!

There are prizes to be won in the new-style Update 2009 – so register now!

Each month all those who complete the CPD for at least one module without making a single mistake will be entered into a £50 prize draw. And those who achieve a year's-worth of correct answers will be entered into a £400 prize draw.

The Update February winner is HK Patel of Bishops Pharmacy, 7 Lyttelton Road, London N2 0DW

Benadryl all month

Benadryl One a Day will be available for pharmacies to order in a new 30-pack (P) from April 6.

Previously only available in GSL packs of seven, Benadryl One a Day contains cetirizine and is formulated to offer daily relief from hayfever and all-year-round allergy symptoms.

The new 30-pack is suitable as a practical purchase for heavy and all-season sufferers, says Sarah Barker, Benadryl senior product manager. She comments: "The launch provides excellent value for customers. Moderate to severe hayfever sufferers will be able to plan ahead and ensure they have a long lasting, effective product to hand."

Price: £9.99/30
Pip code: 344-2647
J&J customer service orders:
Tel: 01628 821327

C+D winners

C+D reader giveaway

Congratulations to the winners of the recent Dorling Kindersley First Aid Manual C+D reader giveaway. They are: Jennifer Bell, James Ryall and Helen Tyler.

Spot on with GSL pack

Dendron is launching a smaller 10g GSL pack of its anti-inflammatory Freederm Gel spot treatment.

The existing 25g presentation (P) is now called Freederm Treatment Gel and is positioned as a more economical option for repeat purchasers.

Containing nicotinamide 4 per cent w/w, the gel is for the topical treatment of mild to moderate inflammatory acne vulgaris.

It is formulated to help tackle the inflammation and redness of spots that are already visible and help stop new ones from forming, says Dendron.

The product should be applied in a thin film twice daily after cleansing the affected and surrounding skin thoroughly with soap and warm water and gently drying.

The launch will be supported by TV ads plus online and other media activity throughout the year. An eye-catching clip-strip encourages self-selection of the 10g pack.

Price: £4.99/10g
Pip code: 331-3277
Dendron; tel: 01923 229251
www.freederm.co.uk

NUK bottles are now BPA-free

The entire UK range of NUK feeding bottles, teats, soothers, training cups and breastfeeding accessories has been relaunched as Bisphenol A (BPA) free. The move follows growing concern about the possible side effects of BPA, a chemical used in the manufacture of clear polycarbonate plastic products.

Anita Bubb, UK marketing manager for NUK, comments: "By developing the whole range as BPA-free, parents have the reassurance they need when choosing products for their babies."

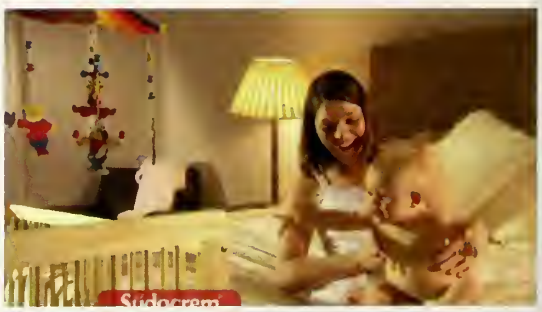
For those NUK bottles with BPA that are still on-shelf until they are replaced by the new range, Mapa Spontex says parents should not microwave them, pour boiling water into them or stir inside them with a metal spoon, as this can cause scratches that increase the chance of BPA leaching into the feed. If bottles show signs of scratches, they should be replaced.

A BPA-free sticker will appear on all new NUK bottles, which can also be identified by their slightly opaque appearance.

Product info:
MAPA Spontex; tel: 01905 450300
www.nukbaby.co.uk

For on TV this week see:
www.chemistanddruggist.co.uk/prodnews

Sudocrem springs up



Sudocrem is back on national TV this spring with a £2 million advertising campaign.

On air until mid April, a 20-second commercial appears in prime time slots including Emmerdale, targeting the brand's core consumer audience of new and expectant mums. The advertising features the message 'The nation's favourite nappy rash cream'.

Two additional 10-second ads are being screened to promote other uses of Sudocrem, such as for cuts and grazes and sunburn.

Product info:
Forest Laboratories UK
Tel: 01322 550550
www.sudocrem.co.uk

Get ready for OTC orlistat

Alli (60mg orlistat) will be launched in the UK this spring by GlaxoSmithKline. It is the only non-prescription weight loss aid to have an EU licence from the European Commission.

The product is indicated for overweight adults with a body mass index of 28kg/m^2 or more. Three capsules should be taken daily before meals and users must follow a reduced calorie, lower fat diet containing around 15g fat per meal.

Used in this way, Alli claims to boost weight loss by 50 per cent. It prevents around 25 per cent of fat in the diet being absorbed so if a low-fat diet is not followed, the patient risks suffering steatorrhoea or leakage from the back passage.

Sales of the product can be made following an initial consultation with the pharmacist lasting 10 to 15 minutes, during which the customer's suitability is assessed and side effects explained.

A consumer support programme includes a recipe guide and an Alli diary available in store, while an interactive website allows dieters to chat to one another.

A TV campaign is planned together with print and online advertising to support the launch.

Packs of 84 (four weeks' supply) and 42 capsules (two weeks' supply) come with a blue case to hold three capsules.

Alli training

GSK is rolling out an extensive Alli training programme for pharmacists and pharmacy assistants to create a team approach to running weight loss consultations. The training includes:

- interactive workshops and seminars to be held over the next 10 weeks at over 60 UK venues
- e-learning modules incorporating a training module for the pharmacy and individual workbooks for pharmacy staff
- a multiple-choice assessment that facilitates CPD for pharmacy training records.

Prices: £49.95/84 capsules, £32.95/42 capsules
GlaxoSmithKline Consumer Healthcare
Tel: 0208 047 2700
www.mypharmassist.co.uk

'All-round fit' claim

Seabond Denture Fixative Seals will be on national TV from April 6 for four weeks as part of a £1 million advertising campaign for the brand this year.

The theme of the TV commercial is 'an all-round fit you can really feel', demonstrating how the product can lock dentures firmly in place so they don't move about and irritate the gums.

The 'all-round fit' claim is also featured on new packs of the wafer-thin soft fixative seals, which peel off easily and are designed so they are not messy to use.

The product comes in two variants, flavour-free original and fresh mint.

Product info:
Combe International
Tel: 0208 680 2711
www.sea-bond.com

Pressure

According to this year's C+D and PDA Union Salary Survey the majority of the profession suffer from stress. Significant numbers also reported problems with motivation and difficulty sleeping, while some cited stress as leading to increased smoking, use of alcohol, depression and in some cases even suicidal thoughts.

C+D decided to bring the issues out in the open by staging a debate on these worrying trends. Present were Priya Sejpal and Heidi Wright, respectively head of professional ethics and head of practice at the RPSGB; Margaret Peycke, NPA external relations manager; PDA Union director John Murphy; Amish Patel, manager of Hodgson Pharmacy in Kent; C+D deputy editor Fiona Salvage and C+D reporter Jennifer Richardson.

James Clegg reports on what they said:

Amish Patel
Manager of Hodgson Pharmacy in Kent

John Murphy
PDA Union director

Margaret Peycke
External relations manager, NPA

Priya Sejpal
Head of professional ethics, RPSGB

Heidi Wright
Head of practice, RPSGB

Fiona Salvage
Deputy editor, C+D

Jennifer Richardson
Reporter, C+D

Stress

FS: There are a lot of stories in the comments section of the questionnaire about pharmacists having problems sleeping or taking medication for depression. Why do we think this is and what can we do about it?

JM: I think everyone's got their head in the sand over this. I genuinely believe the reason people are not addressing this is because they're scared of what they will find. Because absenteeism due to stress is one thing, but 'presenteeism' is another. People feel they have to turn up to work because they're frightened not to or they're frightened to let people down. But they're actually ill.

MP: It can also be very isolated. The interaction and the peer support mechanism are difficult to put in place because of the way the profession works. At least with teachers, even if you all teach in different classrooms you all work in a school and you can say 'oh – that class is terrible' to each other. You've only got one pharmacist in the pharmacy.

Changes

AP: When I talk to other pharmacists I find the older generation are more set in their ways. They're comfortable behind in the dispensary and get stressed if they have to go out in front of the counter. When you've got a routine for 20 years you get into a comfort zone, whereas the younger generation accommodate it because they have been part of it from the start.

JR: Do you think concern about the changing role of pharmacy is a significant factor in stress?

HW: I think a lot of pharmacists feel change is happening to them rather than that they are part of it. How do they come on board and embrace the change and feel this is where they want to be going? Some of the younger ones may want to do this but I don't think it's just an age thing.

JM: If people resist change I think sometimes you have to look at the people implementing that change. People need training and support and that's what British management is bad at. If you're going to make changes then do it properly.

Overworked

FS: Could people be having problems because the hours they work are too long?

PS: Being able to tell your line manager about this kind of thing is important but it's difficult because it might be perceived as weak.

HW: We have to involve multiples in the debate really; if we start picking up these problems you have to open channels of communication with the employer.

JM: I think practical things can be done like

gauge

making sure people take breaks. The longer hours you work the more stressful it is if you don't get a break.

AP: A lot of not taking a break is pressure from customers. I can't take one sometimes because I've got people constantly coming through the door.

Patient safety and expectation

FS: A lot of respondents say they're smoking more, drinking more and not sleeping properly. In light of all this should we be concerned over patient safety?

PS: There is a worry there. If I had one hour's sleep last night I don't know how I'd perform round this table.

FS: Could there also be an issue of workload, meaning that people are expected to dispense prescriptions faster?

JM: One problem is the public automatically assume a prescription is safe so they don't understand why it might take so long.

MP: I'm sure we've all had that. They give the piece of paper over and expect it to appear because people think it's just a pack of pills. They want the correct thing but don't care what happens in between.

PS: A lot of it comes down to public education.

JR: Who picks up the mantle on that? Individual pharmacies, national bodies, multiples or the government?

AP: It has to be the government. Most people probably don't have any idea who the national pharmacy bodies are so only the government has enough impact, really.

Motivation and payment

FS: About half the workforce are struggling with a lack of motivation, which is bad news if we're trying to introduce new services and we're coming up to the launch of vascular risk assessment. How can we change this so the profession can deliver?

JM: I think if we're looking to take these things on we need to be able to pay for them and that means a radical restructure of the whole remuneration system, rather than going to the government, cap in hand.

One idea could be rather than all the contracts going to the bricks and mortar, ie the person who owns the pharmacy, they go with the pharmacist actually carrying out the services. With employed pharmacists now taking the risks in terms of professional and legal accountability, should they be getting the reward?

JR: Is pay a real concern or does every profession feel they are not paid enough?

PS: Dissatisfaction over money can be a reflection on everything else. If they didn't have that worry and they had a good work-life balance I think some people would think they were on quite a good salary.

C+D and PDA Union Salary Survey: how pharmacists are affected

	Employed Pharmacists	Contractors	Locums
Suffer stress	85%	92%	76%
Trouble sleeping	51%	38%	35%
Unmotivated	54%	49%	43%
Drinking more	13%	3%	11%
Smoking more	5%	5%	4%
Suicidal thoughts	5%	0%	4%

For more results go to www.chemistanddruggist.co.uk/salarysurvey

Solutions

In the words of one participant, we can't just "wave a magic wand and make these problems go away". But help is at hand. The RPSGB's Workplace Pressures campaign will hopefully address some of the issues that the survey picked up on, while the PDA and NPA are also keen to get involved with tackling the problem. All pharmacy body representatives who took part said they would feed both the survey results and the discussion back to their organisations.

A diagnosis has been made, now we need to find the right medicine.

C+D & THE PDA union strength in numbers
Salary Survey 2009

The Tricia Show

Jennifer Richardson gets Alliance Boots' services queen Tricia Kennerley on the couch

Many wistful teenage girls may have been inspired by 18th century novels, but it's difficult to imagine Tricia Kennerley ever having been one of them.

The recently promoted healthcare public affairs director of Alliance Boots has leapfrogged up the corporate ladder, negotiating a series of mergers and a highly publicised takeover, since joining Moss Pharmacy as ethical development manager in the mid-1990s.

But, belying her career success within the UK's best-known pharmacy company, entering the profession was not the young Ms Kennerley's foremost ambition. This was simply to study at Bath, the setting for her O-level text, Jane Austen's Northanger Abbey. Ms Kennerley fell in love with the city on a school field trip, and the fact that pharmacy was a respected Bath University course suitable for a science-leaning student was by the by.

That was a world away, though, and as the person responsible for service development at the country's largest pharmacy chain in the so-called services era, Ms Kennerley is now thoroughly enthusiastic about the profession's future.

"I think we have got a really exciting time ahead of us," she says. "I genuinely think there's a lot to be optimistic about the future of the [pharmacist's] role."

The trick, Ms Kennerley says, will be to capitalise on the encouraging noises emanating from government about the profession, in the wake of last April's pharmacy white paper. "The light is shining on pharmacy favourably at the moment from Whitehall, I believe, and I think we really need to seize that opportunity and build upon it."

The most significant barrier to this is, Ms Kennerley believes, the sector's relationship with PCTs. But, echoing PSNC chief executive Sue Sharpe's call at this month's LPC conference for pharmacy to "get over" any acrimony on commissioning, Ms Kennerley says it's up to pharmacy to take the initiative.

"We have to really work hard at developing the relationships with our primary care trusts," she says. "We see that as something that we absolutely want to drive further through pharmacy at a local level."

Parallel to this, Boots has made very effective

use of private patient group directions (PGDs) where services are not commissioned by local PCTs. Ms Kennerley is particularly proud of a cervical cancer vaccination pilot in 10 Boots pharmacies across London, not only because pharmacists trained to administer vaccines open up possibilities for a raft of other immunisation services, but also because of the enthusiastic reaction of patients.

Ms Kennerley says: "It's rewarding from the pharmacists' point of view that we have got people coming in and demanding it."

She wants to see more of this. And that, Ms Kennerley says, involves building relationships with another colleague: "We need to really ensure that we are seen as a serious provider of services and that we work with GPs to be able to do so." This is needed to transform pharmacy services from the current 'pull' model, to Ms Kennerley's ideal of a 'push' scenario.

She explains: "I want to see patients coming in and asking for the service because then we know that... other healthcare professionals are directing patients to come and get services from pharmacy."

Building these relationships will require "ongoing dialogue", Ms Kennerley says. And, while this is important at local level, her recent leap to a group-wide position at Alliance Boots, from her former healthcare development director remit covering Boots UK only, will mean Ms Kennerley's focus will be more strategic, and she's particularly keen to demonstrate outcomes to those who need persuading of the worth of pharmacy services.

Nonetheless, she insists she retains a sense of perspective on what's achievable for an in-store pharmacist – how many services they can reasonably be expected to deliver – from her background as a frontline community pharmacist, which she says is "absolutely" crucial to her role. ("I'm a community pharmacist through and through," she adds.)

In the light of C+D's recent Salary Survey, which unveiled soaring stress levels in the employee pharmacist population, this seems especially important. But, ever commercially minded, it also makes simple business sense for Ms Kennerley. "There's no point delivering a service if people haven't got time to do them," she says. "Number one has to be being able to deliver a great service for our patients in-store all the time."

She adds: "Longer term, and as we see the service agenda growing, we have to recognise that the only way we can really free up time and develop capability in our teams to deliver more services is if we can actually manage our prescription volume in as effective a manner as possible."

Boots is "still interested" in hub and spoke centralised dispensing models to achieve this, Ms Kennerley says, but emphasises that it's also about planning workloads – using repeat prescriptions and quieter out of hours periods to do as much predictable work as possible.

In other words, to use the mantra that Ms Kennerley says will determine her and Alliance Boots' contin… …rly in these recessionary tim… …us." It's a long leap from th… … teenager besotted with … and a dusty book.

Tricia Kennerley CV

Current position:
Healthcare public affairs director, Alliance Boots

Career history:

1988: Manager, independent community pharmacy, Hampshire

1995: Ethical development manager, Moss Pharmacy

2000: NHS Services director, Alliance Pharmacy

2002: Superintendent pharmacist, Alliance Pharmacy

2004: Advanced management programme, Harvard University

2004: Chief services officer and joint managing director, Alliance Pharmacy

2007: Managing director, Alliance Pharmacy, and healthcare director, Boots UK

2008: Healthcare development director, Boots UK

Interests:
Skiing, golf, home improvement/DIY

An ethical dilemma...

This series aims to help you use your professional judgement in making the right decisions when confronted by an ethical dilemma. This month, we ask a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of a topic close to readers' hearts, judging by the C+D postbag. Readers are invited to have their say at **ethics@cmpmedica.com**

Pharmacists' workload

You are employed as manager/pharmacist in charge of one of a group of several pharmacies. Yours is a small shop with a busy counter and prescription trade and at any one time there are a maximum of two assistants working with you. You feel that you are working at full capacity but coping under the current arrangement. The pharmacy owner has just explained that, as a result of recent NHS clawbacks and the credit crunch generally affecting sales growth, you need to make savings and reduce staff costs. The situation worries you – you have a good relationship with your staff, customers and local healthcare professionals but if the workload changes will you be able to cope? What should you do?

A pharmacy practice lecturer says

Your prime concern will be patient safety as set out in the first principle of the Code of Ethics. This includes ensuring that you have access to the resources necessary to provide a professional service to an acceptable standard. In addition, principle two requires you to balance financial and other constraints when acting in your professional capacity. This means that you should not allow your professional integrity to compromise your ability to make informed professional judgements.

As the pharmacist in charge you will need to ensure that you are able to fulfil these obligations. The circumstances under which every pharmacy operates are different; shopping and surgery patterns will dictate busy times of day and the demographics of the local population can affect the dispensing load.

The duties that one pharmacist can easily deal with may leave another feeling stressed and subject to making errors. Consequently there is no set guidance as to hours of work, support staff or prescription numbers with which a single pharmacist should be able to cope, and it will be left to you to organise your workload and resources effectively. The NHS contract does provide some indication of a minimum dispensary staff level required for certain prescription volumes (see Drug Tariff Part VIA).

If you believe that a reduction in support staff and associated increased pressure could result in dispensing errors, you must discuss the situation with the pharmacy owner. You will need to set out the facts that lead you to this conclusion and, if possible, identify some possible solutions. For example, having an accredited checking technician would free your time to develop other services such as MUR and prescription intervention.

Other issues you may wish to consider include security of both staff and stock if the pharmacy is operating with too few personnel, and reducing opening hours by closing for lunch. Much will depend on what is possible for your specific pharmacy location.

Finally if, having explored all the available options, you still feel the conditions are not conducive to safe, effective working and fulfilment of your obligations, you may have to consider looking for alternative employment.

Ruth Rodgers, MRPharmS, PhD, BPharmHons, FIPharmM, senior/clinical lecturer in pharmacy practice, Medway School of Pharmacy, Universities of Kent and Greenwich.

Where does the law stand?

The Working Time Regulations 1998 require that no employee should have to work for more than 48 hours a week and employees should have at least a 20-minute rest break every six hours. It is not clear whether the above employer's new working regime breaches this.

The employer and/or superintendent pharmacist should also be made aware that they may be investigated by the Royal Pharmaceutical Society if a pharmacist or other employee alleges that unsuitable working conditions have caused or contributed to a problem in the pharmacy. Where cases are sufficiently serious to be referred to the Disciplinary Committee (because, for example, dispensing errors have occurred), an allegation of misconduct against the superintendent pharmacist has often included reference to unsuitable working conditions, even if such an allegation is not eventually found proven (no doubt largely because there is no definitive guidance from the Society on this point).

Noel Wardle of Charles Russell Solicitors LLP, specialists in pharmacy law.

> "There is no set guidance as to hours of work, support staff or prescription numbers"

This article can help in the following CPD competencies: **G1h, G1m, G4a, G4d, G4e, G4f, G4h, G4i, G4j, G5f, G7b, C5a.**

See http://tinyurl.com/68ox7b

CPD

Next month: Narcotics

PLEA is an association of pharmacists interested in law and ethics, and lawyers or ethicists specialising in pharmacy, with the aim of promoting understanding of the ethical basis for professional judgement. For more information contact: www.wingfieldworks.co.uk/plea/index.htm

What would you do?

Do you agree with the options laid out here, or can you see another possible solution to this problem?
Email us at ethics@cmpmedica.com

LETHAL OBSESSION

Weight loss is a vital part of cardiovascular risk management and weight loss with Xenical can have a significant impact upon key risk factors.[1-5] When you help change their weight, you help change their future.

Adverse events should be reported.
Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Roche Products Limited.
Please contact Roche Drug Safety Centre on: 01707 367554

Roche

PRESCRIBING INFORMATION. XENICAL (orlistat). Indications: XENICAL is indicated in conjunction with a mildly hypocaloric diet for the treatment of obese patients with a BMI ≥30 kg/m², or BMI ≥28 kg/m² with associated risk factors. Treatment should be discontinued after 12 weeks if patients have been unable to lose ≥5% of their body weight. **Dosage and administration:** One capsule immediately before, during or up to one hour after meals (only 30% of calorie intake from fat). **Contra-indications:** Chronic malabsorption syndrome, cholestasis, breast-feeding, known hypersensitivity to any component of the product. **Precautions:** Monitor anti-diabetic drug treatment. Co-administration of orlistat with ciclosporin is not recommended. Treatment may potentially impair the absorption of fat-soluble vitamins (A, D, E, and K), patients should be advised to have a diet rich in fruit and vegetables. The possibility of experiencing gastrointestinal events may increase when orlistat is taken with a diet high in fat. Caution should be exercised when prescribing to pregnant women. Studies have shown no interaction between orlistat and oral contraceptives, however an additional contraceptive method is recommended to prevent possible failure of oral contraception that could occur in case of severe diarrhoea. Rare cases of rectal bleeding, generally of mild intensity have been reported and prescribers should investigate further if symptoms are severe or persistent. **Drug Interactions:** A decrease in ciclosporin levels has been observed in an interaction study. Co-administration with acarbose should be avoided. INR values should be monitored if patient is on warfarin or other anticoagulants. Reinforcement of clinical and ECG monitoring is warranted if patient is on amiodarone. **Side-effects:** Please consult the Summary of Product Characteristics for full details of adverse events. **Common:** Influenza, anxiety, headache, respiratory infection, urinary tract infection, menstrual irregularity, fatigue and gastrointestinal such as oily spotting, abdominal pain, increased defecation and flatulence. Treatment adverse events in type 2 diabetics included hypoglycaemia and abdominal distension. The incidence of adverse events decreased with prolonged use of orlistat. **Serious:** Very rare cases of increases in liver transaminases and alkaline phosphatase and also cases of hepatitis. Very rare cases of bullous eruptions, diverticulitis and cholelithiasis. Rare hypersensitivity reactions of angioedema, bronchospasm and anaphylaxis. **Legal Category:** POM. **Presentation and Basic NHS Cost:** Xenical 120mg (84 capsules) £33.58. **Marketing Authorisation Number:** EU/1/98/071/003 (84 capsule blister pack). **Marketing Authorisation Holder:** Roche Registration Limited, 6 Falcon Way, Shire Park, Welwyn Garden City, AL7 1TW, UK. Further information is available on request. Xenical is a registered trade mark. **Date of preparation:** June 2007.

References: 1. Hollander PA et al. Diabetes Care 1998; 21: 1288-1294. **2.** Hanefeld M and Sachse G. Diabetes Obes Metab 2002; 4: 415-423. **3.** Sharma AM and Golay A. J Hypertens 1996; 14: 1873-1878. **4.** Broom I et al. Br J Cardiol 2003; 9: 491-495. **5.** Torgerson JS et al. Diabetes Care 2004; 27: 155-161.

XENICAL®
orlistat 120mg

Block fat and help change their future

J9792055T August 2008.

Your QUESTIONS answered

Employment law changes: what do I need to know?

There are several other proposed changes on the horizon, for dates beyond April 2009, which have yet to be confirmed. Gareth Edwards provides the advance warning:

Time off for training

The right to request time off for training will not come into force until April 2010, at the earliest. The proposals are for the request procedure to be modelled on the right to request flexible working (see right). If the proposals are accepted, employees who have completed 26 weeks' continuous service with their employer will have the right to request time off to undertake relevant training. The aim is to encourage employers to invest in their employees' skills as a way of improving business performance. The government does not intend to specify how much time off employees should be allowed for training, but has indicated that requests for time off should be limited to one request in each 12-month period.

Equality Bill

The government has confirmed its commitment to an Equality Bill. One of the main focuses of the Bill is to consolidate current discrimination legislation into one Act. Other proposals include: banning clauses in contracts of employment that prevent employees from discussing their pay; allowing employers to take into account under-representation of a particular group when selecting candidates for appointment or promotion; and requiring public bodies to report on inequalities in gender pay, ethnic minority employment and disability employment.

Do you have a career-related question for C+D?

Email jrichardson@cmpmedica.com and we'll ask the experts

Looking for a new job? Got a staff problem? C+D's new weekly careers section is your one-stop guide to making the right decisions

Law for employers

Get ready for next month's employment law changes, in the second of a two-part series by **Gareth Edwards**

Every employer knows that employment law has become a minefield for the unwary and that those who fail to keep abreast of the changes are heading for an expensive fall. Now that legislation and regulations change in April and October each year, we finish our look at the changes you need to be ready for next month, including an increase in holiday entitlement, increased statutory sick pay, and priority for British workers.

Holiday entitlement

From April 1 statutory annual leave entitlement will increase from 24 to 28 days for those working five or more days per week. This is the final stage of a two-part process to increase statutory holiday entitlement. Employers can currently opt to make a payment in lieu of the additional four-day entitlement that was introduced in October 2007. However, from April 1 statutory holiday entitlement may not be replaced by a payment in lieu.

Despite the increase in entitlement, there is still no statutory right for workers to have time off on public holidays, and this is an issue that can still be dealt with under the terms of the contract of employment. Where employers allow workers to take leave on public holidays, employers are entitled to deduct this from a worker's statutory leave.

However, the reality is that many workers already receive holiday in addition to the statutory entitlement under their contract of employment and many employers allow public holiday to be taken as paid leave in addition to statutory leave.

Statutory sick pay

On and after April 6 eligible employees will be entitled to statutory sick pay at a rate of £79.15 per week, up from £75.40.

Flexible working

The right to request flexible working is currently restricted to parents of children under six (or disabled children under 18), and carers of adult (18+) dependants. There is not yet an exact date, but from April the right to request flexible working will be extended to parents of children up to, and including, the age of 16.

British workers' priority

The home secretary has announced measures to ensure that British workers are given priority for any available job vacancies. Under the current rules employers have to publicise job vacancies for up to two weeks in the UK before advertising overseas. But there is no requirement to advertise the vacancies in a particular place and as a result some employers deliberately place their adverts in obscure places (such as newsagent windows), knowing that not many jobseekers will see the advert.

Now, the government is changing the rules so that employers are forced to advertise job vacancies in Jobcentre Plus branches before advertising abroad. The hope is that this will ensure that thousands of skilled migrant jobs are more readily available to British workers.

Employers that break the new rules face fines of up to £10,000 for each illegal employee, as well as the risk of having their licence to employ non-EU migrants revoked.

Gareth Edwards is a partner in the employment team at Veale Wasbrough Lawyers

And to recap...

Part one of this feature (C+D, March 21, p29) covered dispute resolution and tribunals; statutory maternity, paternity and adoption pay; compensation limits; the national minimum wage and the rights of agency workers.

CAREER TIP of the week

"Keeping your CV up to date is essential because you never know when you might need to apply for a new job. Hypothesisers of the chaos theory of career development, Jim Bright and Robert Pryor, found 70 per cent of a large sample of people said their careers had been significantly influenced by a chance event. So you never know when you'll need your CV in a hurry!" From Brilliant CV, by Jim Bright and Joanne Earl, www.chemistanddruggist.co.uk/booksforjobhunters

brilliant CV

C+D

0207 921 8123

Booking and copy date
12 noon Monday prior
to Saturday publication subject
to availability

Contact:
Andrew Walker
Chemist+Druggist (Classified),
CMP Medica Ltd
Ludgate House
245 Blackfriars Road
London SE1 9UY

T: 0207 921 8123
F: 0207 921 8136

www.chemistanddruggist.co.uk
awalker@cmpmedica.com

Recruitment

The Future of Pharmacy Professional Regulation

Chair and 13 Members

(7 Registrant, 7 Lay)

General Pharmaceutical Council

Working towards a new body for pharmacy professional regulation

Launching in 2010, the General Pharmaceutical Council (GPhC) will be the new regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain. More information on its development can be found at **www.dh.gov.uk,** search under "Pharmacy Professional Regulation"

The Department of Health, on behalf of the Welsh Assembly Government and with the Scottish Government, is setting up the new, independent body to regulate Great Britain's pharmacists, pharmacy technicians and registered retail pharmacies.
This presents exciting opportunities for committed individuals who clearly understand the part regulation plays in public protection.
As members of the inaugural Council, you will be instrumental in setting the strategic direction from the outset.
If you are looking for a challenging leadership position that will see you playing an influential part in shaping high quality, innovative regulation, the GPhC may be able to use your skills and experience.

Chair - Professional or Lay

£48,000 per annum -
approx 6 meetings per year

As a strong, influential and strategic leader, you will possess clear vision along with the capability to establish the new Council. With the highest level of communication skills, you will build strong partnerships with all key stakeholders and be able to command the confidence of the public and pharmacy professions.

13 Council Members - Professional and Lay

£12,000 per annum -
approx 6 meetings per year

You will share collective responsibility for championing public safety and ensuring the GPhC is able to effectively discharge its functions. A key part of early membership will involve ensuring relevant systems are implemented to monitor the organisation's performance.

Members are sought from each of England, Scotland and Wales and it is expected that successful individuals will bring a balanced mix of qualities, skills, experience and credibility to the Council to reflect the diversity of the community and the professions.

For more information and an application pack (also available in large type, Braille or on tape), call 0870 240 3802 quoting reference REG8509 for the Chair post and REG8514 for the Member posts or go to www.appointments.org.uk

Closing date: Tuesday, 21 April 2009.

We value and promote diversity and are committed to equality of opportunity for all and appointments made on merit. We particularly want to hear from women and people from black and minority ethnic communities who are able to make a real contribution to this organisation.

Please note this is a public appointment, not employment.

See **www.appointments.org.uk** or **www.sector1.net** for more public appointments being filled by the Appointments Commission

Appointments Commission

Adding value to public appointments

Recruitment

Peel Green Pharmacy - Pharmacy Dispenser / Assistant

A qualified dispenser needed to work in dispensary and do all jobs associated with dispensing and doing nursing home and community dossettes. Serving on counter and giving advice to customers. Helping Pharmacist do all the days work and help run all aspects of a Pharmacy.

Qualifications and experience preferred. Salary up to 15k

Please contact Nasim Patel on **0161 789 1997** or email CV to **naspatel@googlemail.co.uk**

625, Liverpool Rd, Peel Green, Manchester, Lancashire M30 7BY

Buttercups Training –

aiming to provide the highest quality education and training services for pharmacy support staff.

We are looking for dispensing assistants and pharmacy technicians interested in education and training to work in our South Nottinghamshire office.

The role is dependent upon experience, but could involve assessing the NVQ level 2/3 Pharmacy Services programme, developing new training materials and supporting our students. Newly qualified as well as experienced staff are welcome to apply.

Candidates must have excellent literacy, numeracy and communication skills.

Flexible hours considered.

For an informal discussion telephone **Vanessa Kingsbury 0115 9374936** *or contact by e-mail* **training@buttercups.co.uk** **www.buttercups.co.uk**

GP Dispensary Surrey/Sussex Borders

Dispensary Manager & Dispenser

An exciting opportunity to join an expanding, friendly team.
Manager's position would suit a dynamic, self motivated Dispenser ready for the challenge to manage a small team

We also require a P/T Dispenser

NHS pension
Salary negotiable

For both positions please call Practice Manager on 01428 683174

Services

sexual health resources

Marie Stopes International helps over 100,000 women and men every year with their reproductive and sexual health.

We produce a range of information leaflets helpful for chemists and pharmacies on unplanned pregnancy, abortion, chlamydia, vasectomy and sterilisation.

Call for a **FREE** sexual health pack on
020 7034 2382
www.mariestopes.org.uk

MARIE STOPES INTERNATIONAL

Shop Fitters

www.CMpharmacyinterriors.com

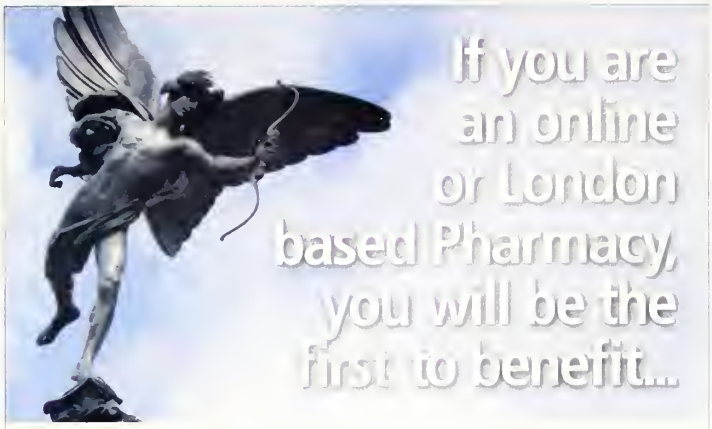
Shop Fitters

Pharmacy design and shop[illegible]
without compromise

www.njlyorkline.com
☎: 0845 450 5904

NJL YORKLINE

Products & Services



...from our new advertising campaign on the London Tube during March and April

STUD 100® Desensitizing Spray for Men is in a class of its own. STUD 100® is licensed by the MHRA for the treatment of over-rapid or premature ejaculation.

STUD 100® costs £2.99 per can (+VAT) and retails for about £5.99 per can. P.O.S. supplied free of charge. Make sure you have adequate stocks. New customers – a Trial 3-Pack is available for £8.97 +VAT (incl. p&p)

TO ORDER OR FOR MORE INFORMATION CONTACT:
Pound International Ltd.,
109 Baker Street, London W1U 6RP
Tel: 020 7935 3735
Fax: 020 7224 3734
E-mail pound@dial.pipex.com

20 MILLION PACKS SOLD WORLDWIDE

Always read the leaflet 844

Locums

LOCUM PHARMACIST'S HANDBOOK

ONE-STOP information source for LOCUM PHARMACISTS.

Contents: Directory of Locum Agency, Specials Manufacturers and Accountancy and Taxation.

For more information and to order your FREE copy email: Locumspress@aol.com

Pharmacies Wanted

allan orme
pharmacy sales & valuations

We have over 900 people on our register, from all over Great Britain, wanting to buy a pharmacy. If you are thinking of selling, give us a call to talk about your next step.

Call **07767 611774** or email: **allanchemist@aol.com**
A C Orme, Cornerstones, Lime Walk, Dibden Purlieu, Southampton SO45 4RB

Pharmacies For Sale

HUTCHINGS PHARMACY SALES

Surrey	T/O	C:	£925,000
Leicester	T/O	C:	£650,000
Cornwall	T/O	C:	£470,000
Dorset	T/O	C:	£400,000
Peak District Derby	T/O	C:	£385,000

THINKING OF SELLING YOUR PHARMACY?

Our 3 Special Reports are a MUST read

"9 Steps to a Successful Pharmacy Sale"
"9 Steps to Minimising the Tax on your Pharmacy Sale"
"9 Most Common Mistakes Made by Pharmacy Sellers"

For your FREE copies either:
call Janine on 01494 722224
or email: info@hutchingsconsultants.com
or visit our website
www.hutchings-pharmacy-sales.com

For a free valuation or discussion about the current market please call Anne Hutchings on the above number

Hutchings Consultants Ltd

"We are the only NPA approved supplier for selling your pharmacy"

NPA

Tax Consultants & Accountants

ARE YOU PLANNING TO SELL YOUR PHARMACY IN THE NEXT 5 YEARS?

Let us help you to maximise your profits by grooming your business for future sale.

We can advise you on:

- How to structure your business to minimise your tax bill when you sell.
- Increasing your turnover.
- Increasing your gross margin.
- Monitoring your expenses.
- Benchmarking your business against similar pharmacies.

For more information please visit:

www.pharmacyexperts.com

or contact **Anne Hutchings** on:

01494 722224

Facsimile: 01494 434764

Email: anne@hutchingsandco.com

h&Co. Hutchings & Co.

Leading Tax Consultants and Accountants for Pharmacies

Finance

Buying Or Re-Financing A Pharmacy? Here's A NEW Service You Need To Know More About

"You Can Now Have Access To More Cash And Significantly Lower Your Equity Requirement Without Any Restrictions On Which Drug Wholesaler You Use"

This NEW service from Pharmacy Partners gives pharmacy owners the following benefits:

- More cash - significantly lowering your equity requirement
- No restrictions on which drug wholesaler you use - claw back valuable margin.
- A more streamlined application process and faster decision making than if you were to approach a bank directly.

To find out more contact Pharmacy Partners NOW!

Tel: 0808 144 5554

E-mail: info@pharmacypartners.com

or visit Web: www.pharmacypartners.com

PHARMACY PARTNERS

SELLING YOUR PHARMACY COULD BE A BITTER PILL TO SWALLOW

MODIPLUS CAN HELP TO:

- Maximise the sale price
- Reduce your Capital Gains Tax to 10% of the gains
- Plan to minimise Inheritance Tax liability
- Introduce you to potential buyers on our database
- And much more...

"Selling my pharmacy could have been a very stressful process. However Modiplus helped me to sell my business by maximising my tax savings. It's the best step I have taken by appointing Modiplus to act for me while selling my business."

MR M PATEL, FORMERLY OF TRIDENT (UK) LTD, LONDON

For more information or for a FREE consultation please call Umesh on:

020 7383 3200

Offices in London and Manchester

www.modiplus.co.uk

Member of Silver Levene Group

THE ONLY REGULATED FIRM OF CHARTERED ACCOUNTANTS AND TAX ADVISERS SPECIALISING IN RETAIL PHARMACY

The Institute of Chartered Accountants in England & Wales

modiplus™ ADDING VALUE

postScript

Open Mike — Mike Hewitson

The not-so-secret diary of a new pharmacy owner

Mike Hewitson is a glutton for punishment. In the midst of economic downturn and with first-time fatherhood looming, he bought his first pharmacy in deepest, darkest Dorset – 100 miles from his former home in Cheltenham. In this regular column, follow Mike's fears, frustration's and step-by-step successes as the new owner of Beaminster Pharmacy.

> "It is my great pleasure to share with you the joyous news that my wife Sarah has given birth to a little girl"

Life changing events – passing your driving test, going to university, getting married, having children – don't come along too often, so when they do you have to make sure you enjoy them.

It is my great pleasure to be able to share with you the joyous news that my wife Sarah has successfully given birth to a little girl. Our daughter, Gracie, was born on Saturday, weighing in at a healthy 8lb 2oz. Mum and baby are both at home and doing well. As most new dads will admit, we could probably do a 30-minute presentation to a complete stranger on the tiniest details of our new offspring. Please allow me one word – "perfect".

My other baby – the pharmacy – has been in the hands of locums all week. One locum, David, gave up his day off at short notice to allow me to be at the birth, a debt I can never repay.

It seems that the whole town is sharing in our joy; we can't walk down the street without someone stopping to ask if they can see the baby. One elderly lady even phoned to request a home visit – from Gracie. So at three days old Gracie has already done her first home delivery!

Tweet of the week

Keep up to date by following C+D on Twitter, an instant messaging service. In the past fortnight, we've amassed almost 50 followers as we've tweeted from the LPC conference and the Numark conference in Dubai (see tweet below). See the news take shape by following our tweets from other conferences, briefings and interviews at **www.twitter.com/chemistdruggist**

"Numark conference: busy morning hearing about how pharmacists can benefit from the credit crunch. And comparing last night's henna tattoos."

Still don't understand what a tweet is? Find out more in our simple guide at **www.chemistanddruggist.co.uk/news**

Mining navel gold

Most people would get the sack for spending their days navel-gazing, but Austrian chemist Georg Steinhauser has turned it into a science.

In a painstaking study of belly button fluff, published in Medical Hypotheses, Dr Steinhauser plumbed the depths of his navel to collect 503 pieces of lint, a total weighing in at almost 1g.

After thorough research and CHNS elemental analysis, he concluded that the fluff matched the shirt he'd worn that day.

Believing his barbed tummy hair trapped shirt fibres, Dr Steinhauser proceeded to shave his belly; the offending fluff soon failed to materialise, supporting his theory. "Questioning male friends, colleagues and family members supported the hypothesis," Dr Steinhauser asserted confidently.

It's good to know science is dedicated to answering the big questions...

Raiders of the Lost Archive

This year is C+D's 150th birthday. Join us as we explore the stories that interested pharmacists back in 1859

1859-2009
Celebrating 150 years in pharmacy

PostScript couldn't help but fall in love with E P Hornby's 150-year-old article, "Boiled bones and guano, which is the best and cheapest fertilizer?"

The feature, taking pride of place in the December 1859 issue of C+D, billed itself as tackling a matter that "none exceed in importance" – a claim that's probably a bit of an exaggeration.

Still, Mr Hornby was so dedicated to answering this burning question he felt the need to launch into a full cost-benefit analysis, happily waxing lyrical about the effect decomposed remains "moistened with liquid manure" can have on the garden.

The author ended by explaining how to apply his excrement-bone mix ("a good dressing is required for grass or seeds") and advising the reader "manufacture for himself" the strange fertilizer.

PostScript will pass, thanks.

Cats may have nine lives...

...you have nine mandatory CPD modules to undertake

Why not register to do your CPD with the leading magazine for pharmacists?

- Gain access to over 40 modules which can be included in your RPSGB Plan and Record portfolio
- Straightforward self-test questions and evidence of completion
- Option of either phone assessment or online assessment with a log sheet to record each CPD activity completed
- Just £32.50 for a full year

Register by phone today on 01732 377269

C+D

supported by

GENUS PHARMACEUTICALS

Every smoker you see faces their own hurdles to successfully Quit. By talking with customers, you can tailor different quitting approaches to each smoker. Help them break their addiction and find the best way to Quit for Good with NiQuitin®.

NiQuitin®

Because different quitters need different answers

Product Information

NiQuitin 2mg/4mg Mint Lozenge and NiQuitin Pre-Quit 4mg Mint Lozenges (nicotine). For relief of nicotine withdrawal symptoms, abrupt/gradual smoking cessation. **Dosage: Adults (18 and over):** *Gradual cessation (Pre-Quit):* Prior to abrupt quit use a lozenge (max. 15/day) when strong urge to smoke to reduce cigarette consumption. Professional advice if no reduction after 6 weeks/quit attempt after 6 months. *Abrupt cessation:* 4 mg if smoke within 30 minutes of waking, 2 mg if longer. Weeks 1 to 6, 1 lozenge every 1 to 2 hours (min. 9, max. 15/day). Weeks 7 to 9, 1 lozenge every 2 to 4 hours. Weeks 10 to 12, 1 lozenge every 4 to 8 hours. Weeks 13-24, 1 to 2 lozenges per day when strongly tempted to smoke. Professional advice if use > 9 months. *Temporary cessation:* 1 lozenge every 1 to 2 hours (max. 15/day). Professional advice after 6 months if using regularly and no quit attempt made. **Adolescents (12-17 years):** Abrupt cessation only. Dosing as for adults but seek professional advice if >12 weeks treatment required/unable to quit abruptly. **Contraindications:** Hypersensitivity, occasional/non-smokers, children under 12 years. **Precautions:** Risk of NRT substantially outweighed by risks of continued smoking in virtually all circumstances. Supervise use in those hospitalised for MI, severe dysrhythmia or CVA who are haemodynamically unstable. Once discharged, can use NiQuitin as normal. Susceptibility to angioedema, urticaria. Renal/hepatic impairment, hyperthyroidism, diabetes, phaeochromocytoma, low sodium diet. Swallowed nicotine may exacerbate oesophagitis, gastric/peptic ulcer. **Pregnancy/lactation:** For those unable to quit unaided the risk of continued smoking is greater than the risk of using NRT. Start treatment as early as possible in pregnancy for 2-3 months. Lozenge/gum preferable to patches unless nauseous. **Side effects:** At recommended doses, NiQuitin Mint Lozenges have not been found to cause any serious adverse effects. Nausea, hiccup, flatulence, GI disturbance, appetite change, oral irritation/ulceration, bleeding gums, halitosis, dizziness, headache, insomnia, nightmares, restlessness, anxiety, palpitations, tachycardia, thirst, taste/sensory disturbance, dyspnoea, pharyngitis, respiratory disorders, rashes, itching, numbness, flushes, throat swelling, chest pain/tightness, lethargy. See SPC for full details. GSL **PL:** 00079/0369, 0370. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack size and RSP:** 36's £8.03, 72's £15.63. **Date of revision:** September 2008.

NiQuitin, Click2Quit and **Pre-Quit** are registered trade marks of the GlaxoSmithKline group of companies.

nicotine

MyPharmAssist.co.uk
The Online Pharmacy Community